PART I: CHILD'S INFORMATION

To be completed by **PARENT/GUARDIAN**

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER.

PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?*	____	____
2. Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	____	____
Date of last eye examination: ____/____/____ Doctor's Name: _____	____	____
Results: _____		
Does your child wear glasses?	____	____
Contact lenses?	____	____
3. Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.)*?	____	____
Date of last hearing evaluation ____/____/____ Doctor's Name: _____		
Results: _____		
Does your child use a hearing aid?	____	____
4. Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.)*?	____	____
5. Does your child have any allergies? If YES, please state what kind of allergies:	____	____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, give details under "Remarks".	____	____
(a) Does this condition require any special health care in the child care facility or school?	____	____
(b) Has your child received evaluation, which could help the child care provider or teacher in meeting his/her health or education needs? If YES, give details under "Remarks".	____	____
(c) Does your child require any adaptive equipment?	____	____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or school teacher should know about? If YES, give details under "Remarks".	____	____

REMARKS (*Clarify any "YES" answers):*

PARENT'S STATEMENT – ALL MUST SIGN AND DATE BELOW

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS IN CHILD CARE OR SCHOOL.

Please fill in, if child is school age:

I give my permission to _____ School to release _____
Name of Child

Health information to _____.
Name of Child Care Center, Family Child Care Home, Non-Public Nursery School

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ Signature of Parent/Guardian _____ Date