Parent/Guardian:

Please complete this form regarding health information on your child.

Has your child ever been hospitalized?	YES	NO
When?		
Why?		
Has your child ever been to an emergency room?		
When?		
Why?		
Does your child take medication?		
What?		
Why?		
When?		
Does your child have allergies?		
What are they?		
Does your child have ear infections?		
How often?		
Does your child have sore throats?		
How often?		
Does your child have nosebleeds?		
How often?		
Does your child get headaches?		
How often?		
Has your child ever had surgery?		
Reason:		
When?		

Does your child have or has your child ever had:

	Yes	No
Chicken Pox		
Strep		
Diabetes		
Seizures		
Asthma		
Scarlet Fever		
Heart Disease		
Epilepsy		
Hayfever		
Congenital Defects		
Explain:		
Bathroom Accidents		
How often?		

Thank you for taking the time to complete this form. This information will enable us to be sure your child receives the best care possible during his/her day at school.

EPCUSD401 Health Services

_______________________________________ _______________________________________

Parent Name (please print) Parent signature

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Date