Health History - High Scope Learning Care

Child's Name

First Name Last Name

Birth Date

Month Day Year

Last Physical Examination Date

Month Day Year

Has your child has any of these illness?

- ☐ Constipation
- ☐ Convulsions
- ☐ Diarrhea
- ☐ Fainting Spells
- ☐ Frequent Colds
- ☐ Frequent Ear Infections
- ☐ Frequent Sore Throats
- ☐ Lice
- ☐ Ringworm
- ☐ Skin Rash
- ☐ Soiling
- ☐ Stomach Upsets
- ☐ Urinary Problem
- ☐ Worms

Has your child has any of these illness?

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Impetigo
- ☐ Measles
- ☐ Mumps
- ☐ German Measles
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Whooping Cough

Other Illness

Has your child been hospitalized?

Has your child had INJURIES with fractures or loss of consciousness? (explain)

Last Vision Test Date

Month Day Year

Last Hearing Test Date

Month Day Year

Last Dentist Visit Date

Month Day Year

Any other member of family with serious illness recently?

Any other member of family history of Asthma, Diabetes, Epilepsy?

Signature

Date

Month Day Year