JCC WALK
Children's Center | 8 Weeks to Pre-k

2018–2019 HEALTH HISTORY

Child's Health History

Child's Name: _____ **Date of Birth:** _____

Please complete the following health-related questions and **attach a copy of your child's "Health Assessment" or "School Form" (with immunization records) prepared by a Pediatrician. To grant permission to administer ANY medications (including over the counter) an OCFS Written Medication Consent form must be completed as well.**

Does you child have any of the following:	Yes	No
1. Diabetes	☐	☐
2. Asthma	☐	☐
3. Seizures	☐	☐
4. Ear infections	☐	☐
5. Frequent colds	☐	☐
6. Allergies: _____	☐	☐
7. Hearing impairment	☐	☐
8. Difficulty with speech	☐	☐
9. Vision impairment or difficulty	☐	☐
10. Medications* (please list to the right)	☐	☐

Does your child have any special needs or health concerns for which s/he is receiving therapies or medical treatment? Please describe.

_____

_____

_____

_____

***Please list child's medication to be administered during the school day:**

_____

_____

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs, please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	**Phone:**
Child's Source of Dental Care/Dentist Name:	**Phone:**
Name of Medical Care Facility/Hospital:	**Phone:**

Emergency Contact

First preferred contact (In case we need to reach you – in other words, who should we call first?)

Name: _____ Phone: _____

Second preferred contact (In case we need to reach you – in other words, who should we call second?)

Name: _____ Phone: _____

Help us get to know your child

Primary Language: ☐ English ☐ Other_____ Toilet Trained: ☐ Yes, fully ☐ Partial ☐ Not yet

Favorite activities:
Meal time issues (if any):
Causes for concern: ☐ Separation ☐ Crying ☐ Temper ☐ Biting ☐ Other_____
What method of behavior management is used at home: ☐ Redirection ☐ Time out ☐ Ignoring ☐ Other_____

What are you most proud of about your child?

_____

_____

_____

_____

What are your goals for your child in our program?

_____

_____

_____

_____

What are your child's nap habits?

_____

_____

_____

_____

Use this space to share with our teachers anything else that you feel is important for us to know about your child.

_____

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