

Special Care Needs

Child's Name: _____ Date: _____

Help us serve your family better by answering the following questions.

Does your child experience any of the following?

Heart Trouble	Yes	No	Comments _____
Asthma	Yes	No	Comments _____
Convulsions/Seizures	Yes	No	Comments _____
Diabetes	Yes	No	Comments _____
Allergies to medications	Yes	No	Comments _____
Allergies to food	Yes	No	Comments _____
Other Allergies	Yes	No	Comments _____
Existing or recent illness	Yes	No	Comments _____
Existing or recent injury	Yes	No	Comments _____

Does your child have any special care needs? This includes but is not limited to: allergies, existing illness, previous serious illness and injuries, hospitalization during the past 12 months, and any medications prescribed for continuous long-term use.

Circle YES or NO

If YES, please describe: _____

Has your family had any major life changes in the past 6 months?

Circle YES or NO

If YES, please describe: _____

Other important information: _____

Parent/Guardian Signature _____ Date _____