Lizzy E's school for Exceptional Learners Health Records.

Enrollment date/date of application:_____

*DOES YOUR CHILD HAVE ANY ALLERGIES THAT YOU ARE AWARE OF? List any known below.

_____

-Are you concerned that your child may be prone to any type of allergies (such as allergies that run in the family that your child may have not yet been exposed to yet)? If so please describe_____

_____

-Child's Primary Physician's name:_____

-Name of the Office where this Doctor practices:_____

-Are your child's immunizations up to date? YES_____ NO_____ (please attach a copy of your child's updated immunization record)

-Does your child have any medical conditions we should be aware of? YES_____ NO_____ If yes,

please describe_____

-Does your child see a dentist regularly? (Please check one) YES_____ NO_____

If yes, What is the Dentist's name/Practice name who your child sees?_____

-Does your child have any speech, hearing, or visual problems? YES_____ NO_____ If yes, please

Describe_____

*Has your child ever had any of the following diseases? (circle all that apply)

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

*Does your child have problems with any of the following (apart from normal childhood illnesses/occurrences)

Constipation	Convulsions
Diarrhea	Fainting Spells
Frequent Colds	Frequent Ear Infections
Lice	Frequent Sore Throats
Ringworm	Skin Rashes
Soiling	Stomach Upset
Urinary Problems	Worms

Lizzy E's School for Exceptional Learning, Important Questionnaire

~Do you plan for you child to attend all 4 days of our Mon--Thurs program? YES_____ *NO_____

*if no, which day(s) you plan for your child to attend?_____

~Has your child ever attended a pre-school and or daycare setting before?

YES_____ *if yes, do you feel your child had a positive experience with this in the past?_____

NO_____ *if no, how do you feel your child will react to being left at school/daycare without you?

_____

~Have there been any recent traumatic situations at home that the child has been exposed to such as a new sibling, a family move, divorce, death in the family etc? YES_____ NO_____

*if yes, please explain_____

~What is your normal method of discipline?_____

~What would you say is your child's general temperament? Are they easy going, hard to please, demanding, aggressive? Etc...

_____

~Any food restrictions? YES (List if any)_____ NO_____

~Child's favorite food/foods? _____Least favorite food/foods_____

~Is your child potty trained? YES NO *if yes, can they be relied upon to indicate bathroom wishes? YES NO (circle one)

~What words does your child use to communicate the need to use the potty? #1_____ #2_____

~How many hours of sleep does your child get a night? _____ ~Does he/she sleep through the night? YES NO (circle one)

~Does your child have any siblings? YES NO (circle one) * if yes, please list how many brothers/sisters and ages.

_____

~Has your child had experience playing with other children his or her own age? YES NO (circle one)

~What language(s) are spoken in the home? _____

~Does your child have any security objects? Such as, blanket, bottle, soother, toy. Etc..?_____

~~~~Anything else you think we should know about your child?_____

_____

_____

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