Blooming Littles Learning Center

Health and Background Summary

Child's Name: _____ DOB_____

_____

Name, address, phone number of child's doctor

_____

Name, address, phone number of child's dentist

Is your child fully immunized? **Completed immunization records must be provided on or before the first day's attendance.**

Does your child have a doctor diagnosed chronic medical condition? Yes_____ No_____

If yes, please explain:_____. **If yes, a health care action plan must be completed by a doctor before the first day's attendance.**

If your child has doctor diagnosed allergies to food, medicine, insects, or other things please list:

1. Allergy:_____
   Reaction:_____
2. Allergy:_____
   Reaction:_____

Does your child have a history of:

Seizures: Yes__ No__ ***Diabetes***: Yes__ No__ ***Asthma***: Yes__ No__

Does your child have a medically prescribed diet or dietary restrictions? Yes_____ No_____

If yes, please explain:_____.

Does your child have food/environmental sensitivities? If so , please list and explain reactions and care: _____

_____

Does your child have an IEP? Yes__ No__ Can we get a copy of that? Yes__ No __

Are there any other health concerns to share with us?_____.

Does your child wear glasses or contact lenses? Yes_____ No_____

Please describe in detail (on the back of this form) any behavior issues – triggers, situations, solutions/tactics.