MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH HISTORY FORM
For Use in Drop-In Child Care Centers

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____ Relationship: _____

To be completed by the Parent/Guardian.

Check the appropriate box below. Give a brief explanation under COMMENTS for any YES answer.

Does the child have any of the following?	YES	NO	COMMENTS
a) Vision problem?	☐	☐	
b) Hearing problem?	☐	☐	
c) Speech or language problem?	☐	☐	
d) Physical illness or impairment problem?	☐	☐	
e) Mental, emotional or behavioral problem?	☐	☐	
f) Developmental delay?	☐	☐	
g) Allergies?	☐	☐	
h) Other? *(If YES, specify)*	☐	☐	
i) Health condition which may require care or emergency action? *(If YES, specify, e.g. seizures, bee sting allergy, diabetes, etc.)*	☐	☐	
j) Does the child have up-to-date immunizations?	☐	☐	
k) Is the child currently taking any medication?	☐	☐	
l) Mobility assistive devices?	☐	☐	

This child is otherwise in good physical and mental health. This child is also free of communicable disease and may participate fully in all activities. YES: ☐ NO: ☐

List any areas of the program in which the child cannot fully participate	Would any limits or alterations help to meet his or her needs?	Please explain briefly

Signature of Parent/Guardian Date

Review and update this form each time the child is in care. If no changes, please initial and date below.

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