Our Savior Early Learning Center

DEVELOPMENTAL HISTORY

CHILD'S NAME:
DATE OF BIRTH:
GENDER:

HEALTH

IF YOU MARK YES TO ANY OF THE BELOW QUESTIONS, PLEASE DESCRIBE

1. DOES YOUR CHILD SEEM WELL MOST OF THE TIME?	☐ YES	☐ NO
2. IS YOUR CHILD TAKING ANY MEDICATIONS NOW? (INCLUDING ASPIRIN, LAXATIVES, VITAMINS, ETC.)	☐ YES	☐ NO
3. IN A YEAR HAS YOUR CHILD HAD AS MANY AS 3 EAR INFECTIONS?	☐ YES	☐ NO
4. ARE YOU CONCERNED ABOUT YOUR CHILD'S HEARING?	☐ YES	☐ NO
5. IN A YEAR, DOES YOUR CHILD USUALLY HAVE MORE THAN 3 COLDS OR SORE THROAT INFECTIONS WITH A FEVER?	☐ YES	☐ NO
6. ARE YOU CONCERNED ABOUT YOUR CHILD'S EYES OR VISION?	☐ YES	☐ NO
7. HAS YOUR CHILD BEEN SEEN BY A MEDICAL SPECIALIST? IF YES, WHO?	☐ YES	☐ NO
8. DOES YOUR CHILD HAVE ANY HANDICAPS?	☐ YES	☐ NO
9. OTHER ILLNESSES OR DIABETES?	☐ YES	☐ NO
10. DOES YOUR CHILD HAVE ANY CONTAGIOUS ILLNESSES THAT COULD IMPACT OTHERS (MALARIA, HEPATITIS A, HEPATITIS B, HIV, AIDS, ETC.)?	☐ YES	☐ NO
11. HAS YOUR CHILD BEEN HOSPITALIZED?	☐ YES	☐ NO

12. HAS YOUR CHILD HAD ANY OF THE FOLLOWING (CIRCLE ALL THAT APPLY):

PREMATURE BIRTH
BIRTH INJURY OR DEFECT
TROUBLE BREATHING
HEAD INJURY
ALLERGIES (ECZEMA, HIVES, DRUG, FOOD, INTOLERANCE, HAY FEVER, WHEEZING, ASTHMA, INSECT STINGS?)
PLEASE LIST SPECIFIC ALLERGIES: