



STUDENT MEDICAL RECORD

20__ - 20__
LUCY DANIELS CENTER FOR EARLY CHILDHOOD



Child Name: _____ Parent's Name: _____

Birth Date: _____ Start Date: _____ Class: _____

PAGE TO BE COMPLETED BY PARENT

Medical History

1. Is your child allergic to anything (include medications, insect, foods)? No ___ Yes ___

Specify: _____

2. Does your child currently receiving medical attention for any condition, acute or longstanding?
No ___ Yes ___ Specify: _____

3. Is your child on any regular medication? No ___ Yes ___

Specify: _____

4. Has your child had any significant previous diseases or recurrent illness? No ___ Yes ___

Diabetes: No ___ Yes ___

Epilepsy: No ___ Yes ___

Cardiac abnormalities No ___ Yes ___

Regular ear infections No ___ Yes ___

Frequent nose bleeds No ___ Yes ___

Strep throat (more than one) No ___ Yes ___

Specify: _____

5. Does the child have any physical disabilities? No ___ Yes ___

Specify: _____

6. Does your child have any emotional difficulties, substantial developmental lags, or learning difficulties? No ___ Yes ___

Specify: _____

7. Does the child have any fears? No ___ Yes ___

Specify: _____

Signature of Parent or Guardian

Date