HOME HEALTH INFORMATION (PRESCHOOL)

Name of Student: _____ Nickname (if any): _____ Birthdate:_____
Street Address: _____ P.O. Box #: _____
City, State, Zip: _____
Home Telephone #: _____ Home Email: _____

Parent/Guardian 1 Name: _____ Cell #: _____
Occupation & Employer: _____
Work Email: _____ Work #: _____

Parent/Guardian 2 Name: _____ Cell #: _____
Occupation & Employer: _____
Work Email: _____ Work #: _____

DOES YOUR STUDENT HAVE ANY:

- Allergies? _____
- Difficulties with speech, vision, or hearing? _____
- History of hospitalization or surgery? _____
- Daily medication(s)? _____
- Special interests? _____
- Fears? _____
- Responsibilities at home? _____

What parent/guardian(s) does your student live with?

_____

Please list the names and ages of your student's siblings: _____

_____

Please list names and relationship to child of people who can access your child's health records. Please include yourself.

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Additional information that would help us understand your student better:

_____

_____

_____