Jefferson Center for Preschool Children PO Box 218, 6 York Street Codorus, PA 17311

Medical History

Name of Child: _____ Birthdate: _____

1. Is the child allergic to anything? **Yes or No**

If yes, to what?_____

_____

If yes, explain how severe and what happens._____

_____

_____

2. Is the child currently under a doctor's care? **Yes or No**

If yes, for what reason?_____

3. Is the child on any continuous medication? **Yes or No**

If yes, what and why? _____

_____

4. Any previous hospitalizations or operations? **Yes or No**

If yes, when and for what? _____

_____

5. Any history of significant previous diseases or recurrent illness? **Yes or No**

☐ Diabetes ☐ Convulsions ☐ Heart Trouble ☐ Other (describe)_____

Please give details of occurrences of this disease/illness: _____

_____

6. Does the child have any physical disabilities? **Yes or No**

If yes, please describe: _____

_____

7. Does the child have any mental disabilities? **Yes or No**

If yes, please describe: _____

_____

8. Please describe any other physical, mental or emotional conditions that JCPC staff should be aware of:_____

_____

_____

Please complete and return this form before your child's first day of class.