



**Health & Medical Form**

HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined _____ within the past year and find that they are physically able to take part in the preschool program.	
_____	_____
Health Care Professional's Signature	Date

**Student's Health Information** (Attach Explanations for any "YES" answer back of sheet)  
**(Please attach a copy of your child's immunization card as required by Texas state law)**

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Chicken Pox			Asthma			ADD/ADHS		
Mumps			Hay Fever			Tonsillitis		
Measles			Tuberculosis			Ear/ Stomach Aches		
Diabetes			Small Pox			Seizures		
Hepatitis			Hives			Insect Allergies		
Scarlet Fever			HIV/Aids			Frequent Colds		
Hearing Loss*			Obits Media					

\*If yes, Hearing Aid (\_\_\_\_), Cochlear Implant (\_\_\_\_) Other (\_\_\_\_)

Cause of Deafness: \_\_\_\_\_

Food Restrictions: \_\_\_\_\_

Severe Allergies: \_\_\_\_\_

**Helpful Information for our staff:**

Describe your family's forms of discipline: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe your child's sleeping habits: Nap time \_\_\_\_\_

\_\_\_\_\_

Bedtime: \_\_\_\_\_

\_\_\_\_\_

Is your child potty trained? \_\_\_\_\_ If not describe steps you are taking toward that process: \_\_\_\_\_

\_\_\_\_\_