



Child's Preliminary Health Information

Child's Name _____
Last First Middle

Has your child ever used an inhaler or a nebulizer in the home? no yes

Does your child have any of the following:

- Health Concerns no yes
- Asthma no yes
- Allergies (food, medicine or pollens) no yes
- Special Diet no yes
- Speech Concerns no yes
- An IEP/IFSP no yes

If YES to any of the above please explain: _____

Child's Current Health Insurance _____ Dental Insurance _____

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

White – Nurse

Yellow – Child's File