

# Medical History Form

Child's Name \_\_\_\_\_

Is your child allergic to any of the following?  
(If so please describe)

Food or beverages \_\_\_\_\_

Other \_\_\_\_\_

Does your child have any medical conditions that we should be aware of?  
(If so please explain)

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Does your child have any special needs?

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**We will also need a copy of your Childs immunization records to keep on file.**