Farragut Presbyterian Church
Children's Enrichment Program

Child's History Checklist

Child's Name:_____Birth Date:____/____/_____

Parent/Guardian's Name: _____

Your answers to the following questions will help us identify if your child has any medical problems that we should be aware of. We need this information in case he/she should become ill and we would be unable to reach you right away. Please answer all questions.

Pregnancy and Birth

☐YES ☐NO 1. Were there any problems with pregnancy or your child's birth?
☐YES ☐NO 2. Was his/her birth weight under 5 ½ pounds?
☐YES ☐NO 3. Did the baby have any problems in the hospital?

Medical History

☐YES ☐NO 4. Is your child able to play as hard as other children?
☐YES ☐NO 5. Is your child taking any medications?
☐YES ☐NO 6. Any allergies or reactions to medicine, shots or insects?
☐YES ☐NO 7. Has your child had asthma or wheezing?
☐YES ☐NO 8. Does your child have speech or hearing problems?
☐YES ☐NO 9. Has your child had more than two (2) ear infections in a year?
☐YES ☐NO 10. Has your child had tonsillitis?
☐YES ☐NO 11. Does your child have trouble with his/her eyesight?
☐YES ☐NO 12. Has your child ever had a bladder or kidney infection?
☐YES ☐NO 13. Does he/she have burning when urinating?
☐YES ☐NO 14. Does he/she have seizures, fits or shaking spells?
☐YES ☐NO 15. Have you ever been told that your child has a heart murmur?
☐YES ☐NO 16. Has your child ever been hospitalized overnight?
☐YES ☐NO 17. Has your child ever had a bumpy, swollen reaction to the TB skin test?
☐YES ☐NO 18. Has your child ever been with anyone having TB?
☐YES ☐NO 19. Has your child ever had worms?
☐YES ☐NO 20. Does your child scratch his/her genital area?
☐YES ☐NO 21. Is his/her bottom/genitals red or sore?
☐YES ☐NO 22. Is your child a hemophiliac (free bleeder)?
☐YES ☐NO 23. Does your child have tubes in his/her ears?

General Development

☐YES ☐NO 24. Does your child get along well with other children?
☐YES ☐NO 25. Is your child usually happy?
☐YES ☐NO 26. Does your child have any special problems not indicated by this form?

When did your child last see his/her pediatrician? Month/Year_____/_____