



423 3rd St SW, Albuquerque, NM 87102

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Child Health Information Form (24m-5y)

This form must be completed and signed by a physician.

Child's Name: _____ Child's Date of Birth: _____

1. Date of most recent Well Child Check: _____
2. Date of most recent Vision Screening: _____
3. Date of most recent Hearing Screening: _____
4. Date of most recent Dental Screening/Exam: _____

5. Are immunizations up-to-date? Yes No (Please attach a copy of most current Immunization record)

If immunizations are not current, please explain:

6. Does this child have any of the following? If yes, please check and describe.

- Allergies Epipen **(Epi-pens must be checked in to administration for the child to attend.)**
 Abnormal result on a hearing test
 Abnormal result on a vision test
 Recurring chronic illness/health problems
 Disabilities such as cerebral palsy, seizure disorder, developmental delay, or any other condition that might require a medical plan on file. **If so, a physician certified plan must be on file before the child's first day of enrollment.**

If you checked any of the above, please explain and provide any follow-up measures, additional information necessary, or regular medications this child takes.

7. Does this child have an IFSP or IEP? Yes No

- Service/Organization Provider: _____

- Services Received:

8. Does this child have any special dietary or medical food needs such as restrictions, allergies, or sensitivities? Yes No

- Please provide any details regarding needs, symptoms, alternatives, medications, or medical plans that relate to this child's dietary or medical food needs:

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Physician Signature

Date

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Guardian Signature

Date