MUNICIPALITY OF ANCHORAGE
DHHS CHILD/ADULT CARE PROGRAM

SUMMER CHILD CARE
CHILDREN'S HEALTH HISTORY FORM

Center: ______________________________

Form is to be filled out by child's parent or guardian

Child's Name (Print) ____________________ ______________ MI _____ Date of Birth_____________
Last First

A. Has your child had problems with any of the following? If so describe the problem.

	YES	NO	
1.			Eyes/Vision
2.			Ears/Hearing
3.			Nose/Throat
4.			Mouth/Teeth
5.			Speech
6.			Skin
7.			Lungs/shortness of breath, persistent hoarseness, asthma
8.			Heart, chest pain, palpitations
9.			Blood disorders, anemia
10.			Nervous system
11.			Orthopedic: gait, joints, paralysis
12.			Abdomen-Hernia
13.			Headaches, dizziness, fainting, convulsions, seizures
14.			Mental, nervous, or emotional disorder
15.			Diarrhea, salmonella, shigella or giardia
16.			Allergies to the following:
17.			Any mental, emotional or physical disorder not listed above: ________________________________

B. **What medications is your child using?** ____.

C. **Is your child under any form of treatment or observation? If so describe**. ______________________
____
____.

D. **Is your child able to participate in usual group activities: Yes ____ No ____**

E. **Are there any restrictions required for your child in this program: Yes ____ No ____**
If you answered "Yes", describe:____
____

F. **IMMUNIZATION RECORD**

If your child has been attending an Anchorage School District Elementary School, or a private elementary school under the direction of the Alaska Department of Education, please fill out the following:

Name of School ______________________________ Location______________________________

Date of Immunization	Date of Immunization	Date of Immunization
1. DPT ____________________	1. OPV ____________________	1. MMR ____________________
2. DPT ____________________	2. OPV ____________________	
3. DPT ____________________	3. OPV ____________________	
4. DPT ____________________	4. OPV ____________________	
5. DPT ____________________		

If your child attended a school outside of the Anchorage School District, please provide a document of immunizations.

G. **I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE AND COMPLETED TO THE BEST OF MY KNOWLEDGE**.

Parent's Printed Name: ____

Parent's Signature: ____ Date: ____________________