

**LITTLE GREEN SPROUTS PRESCHOOL
HEALTH QUESTIONNAIRE**

Child's Name: _____ Date of Birth: _____

Please list any health issues or problems of which we should be aware:

Hearing: _____

Vision: _____

Developmental: _____

Language/Speech: _____

Seasonal Allergies: _____

Allergy Medication Child is Taking: _____

Insect bites/stings: _____

Food: _____

Asthma: _____

Asthma Medication: _____

Other: _____

Additional Medical History (Please use a second sheet if necessary): _____

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____