

# St. William Early Childhood Development Center Health Statement

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Disease child has had: (Please check all that apply)

Chicken Pox                       Measles                       Mumps  
 Whooping Cough                       Polio                       Scarlet Fever  
 Diphtheria

List any known allergies:

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Does child: (Please check all that apply)

Use Left Hand                       Use Right Hand                       Have Poor Vision  
 Have Poor Hearing                       Speech Difficulty                       Nervous Habits

Please explain any items checked: \_\_\_\_\_

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**If your child is 4 years old as of September 1st,** a Vision and Hearing screening is required by the state for our records.

Vision Screening     Passed     Failed     Did not cooperate

Hearing Screening     Passed     Failed     Did not cooperate

The above child has been examined by a licensed physician within the past year. This child is physically able to take part in an Early Childhood Development Center program. **The child is also current on all immunizations.**

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_