CORNERSTONE WEEKDAY PRESCHOOL
STUDENT HEALTH FORM
2024-2025

Name: ____

Medical History (to be completed by parent or guardian)

1. Does your child have any allergies? ☐ yes ☐ no
   If yes, please provide details and describe severity: ______________________________
   ____

2. Is your child on any continuous medication? ☐ yes ☐ no
   If yes, please list the name of the medication(s) and the reason it is being given: __________
   ____
   ____

3. Has your child ever been hospitalized? ☐ yes ☐ no
   If yes, please list dates and reasons for hospitalization: ______________________________
   ____

4. Does your child have any history of:

• diabetes	☐ yes	☐ no
• convulsions	☐ yes	☐ no
• heart problems	☐ yes	☐ no
• significant disease or recurrent illness (please list)	☐ yes	☐ no
• other conditions (please list)	☐ yes	☐ no
• ______________________________		

5. Does your child have any mental or physical disabilities? ☐ yes ☐ no
   If yes, please explain: ______________________________
   ____

6. If you would like for us to administer non-prescription topical ointments if needed during the school day please indicate below:

First Aid Ointment ☐ yes ☐ no
Neosporin Wound Cleanser for Kids, A&D Ointment, Aquaphor

Benadryl Gel Children's Anti-Itch Cool Gel ☐ yes ☐ no

____ ____________________

Parent/Guardian Signature **Date**