Stepping Stone Learning Center, Inc

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HEALTH QUESTIONAIRE
FORM E

STUDENT'S NAME_____DATE_____

Date Of Birth_____ Grade_____ Sex_____

Place of Birth_____
City County State

Doctors Name_____ Phone Number_____

Address_____ Last Exam Date_____

Health Insurance Carrier/Company/Policy #_____

Authorized To Call Doctor? ☐ Yes ☐ No Authorized to Call Rescue Squad? ☐ Yes ☐ No

Hospital Preferred:_____

Dentist's Information_____
Name Address Phone Number

Date of Last Checkup_____ Dental Insurance_____

Any Chronic Illness_____ Surgery_____

Allergies_____ Regular Medication_____

Any Special health concerns or special instructions for your child?_____
_____

Does Your Child Have?

☐ Speech Difficulty ☐ Neurological Disorder ☐ ADD ☐ Hearing Loss
☐ Physical Limitations ☐ Learning Disability ☐ Vision Difficulty

Information not listed on forms that you would like staff to be informed of?_____
_____
_____
_____