AnNur Islamic School

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Phone (518) 395-9866 Fax (518) 395-9867

Child's Name: _____
Last First Middle

Sex: M ☐ F ☐ DOB: _____ Age: _____

Address: _____Home Phone: _____Work Phone_____

School: _____ Grade Entering: _____ Today's date: _____

Pediatrician: _____ Phone number: _____ Preferred hospital: _____

Dentist: _____ Phone number:_____

Please check below if your doctor ever said your child had problems with any of the following:

Asthma/Breathing		Broken bones		Behavior problems	
Bleeding		Cancer		Cavities/dental problems	
Headaches		Chicken Pox		Ear infections/tubes	
Heart condition		Diabetes		Facial tics	
Kidney condition		Head Injury/Concussion		Hearing problems	
Nose bleeds		Meningitis		Problems running/walking	
Painful joints		Pneumonia		Speech difficulties	
Skin condition		Rheumatic Fever		Surgery	
Stomach/Bowel		Tuberculosis		Vision Problems	
Urinary condition		Whooping Cough		Seizure Disorder	

If you checked any boxes above, please explain: _____

_____

Is your child receiving medication for any of the above conditions? Yes ☐ No ☐

If yes, drug, dosage and frequency: _____

Has your child ever had an allergy evaluation by a specialist? (If yes, give date) _____

Allergies: Please specify agent or food (ex. Bee sting): _____

Will your child need medication to be administered in school? Yes ☐ No ☐

Has your child ever been hospitalized since birth? Yes ☐ No ☐

Any other information you wish to share: _____

_____

_____ _____

Signature Relationship to child