

If your child is ever ill or injured and requires emergency care, doctors, nurses, and paramedics will have many questions about his or her medical history. It is important to keep a complete record of your child's health information nearby. This information may help a medical professional make quicker decisions during an emergency, when each second counts.

## Health History & Information

**Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Parent/Guardian Name(s):** \_\_\_\_\_

**Child's doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Child's dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

<p><b>Medicines currently taking:</b> (name of medicine and dose)</p> <p>name _____ dose _____</p> <p>name _____ dose _____</p> <p>name _____ dose _____</p>	
<p><b>Past hospitalizations:</b></p> <p>reason for hospitalization _____ date _____</p> <p>reason for hospitalization _____ date _____</p>	
<p><b>Illnesses</b> (check all that apply)</p> <p><input type="checkbox"/> asthma                      <input type="checkbox"/> heart disease</p> <p><input type="checkbox"/> diabetes                      <input type="checkbox"/> heart murmur</p> <p><input type="checkbox"/> epilepsy/seizures            <input type="checkbox"/> cancer</p> <p><input type="checkbox"/> ear infections/ tubes        <input type="checkbox"/> migraines</p> <p><input type="checkbox"/> hemophilia</p> <p><input type="checkbox"/> other: _____</p>	<p><b>Allergies</b> (check all that apply)</p> <p><input type="checkbox"/> medicines (specify): _____</p> <p><input type="checkbox"/> food (specify): _____</p> <p><input type="checkbox"/> animals (specify): _____</p> <p><input type="checkbox"/> insects (specify): _____</p> <p><input type="checkbox"/> plants (specify): _____</p> <p><input type="checkbox"/> other: _____</p>
<p><b>Past injuries</b> (check all that apply)</p> <p><input type="checkbox"/> dislocation: _____</p> <p><input type="checkbox"/> sprain: _____</p> <p><input type="checkbox"/> fracture: _____</p> <p><input type="checkbox"/> ligament/tendon: _____</p> <p><input type="checkbox"/> plants (specify): _____</p> <p><input type="checkbox"/> other: _____</p>	<p><b>Other health conditions</b> (check all that apply)</p> <p><input type="checkbox"/> fainting                      <input type="checkbox"/> nose bleeds</p> <p><input type="checkbox"/> hearing impaired          <input type="checkbox"/> ADD/ADHD</p> <p><input type="checkbox"/> glasses                      <input type="checkbox"/> sickle cell anemia</p> <p><input type="checkbox"/> contact lenses              <input type="checkbox"/> motion sickness</p> <p><input type="checkbox"/> other _____</p>
<p><b>Immunizations are up-to-date:</b>    <input type="checkbox"/> yes    <input type="checkbox"/> no</p>	

Notes \_\_\_\_\_

*Brought to you by Parent Help Line at HSHS St. John's Children's Hospital  
to help keep kids safe, healthy and happy.*



**Call the Parent Help Line. Help is just a phone call away.**

1-217-544-5808 or 1-888-727-5889  
10 a.m. to 10 p.m., 7 days a week  
[www.parenthelpline.org](http://www.parenthelpline.org)

