



Berkeley Hills Preschool
517 Sangree Road
Pittsburgh, PA 15237

Health Form

Date _____

Class _____

School Year _____

Child's name _____ Birthdate _____

Address _____ Home phone _____

City _____ State _____ Zip code _____

Father's name _____ Employer _____ Business phone _____

Mother's name _____ Employer _____ Business phone _____

In case of emergency, parent or guardian will be notified by phone. In the event that you cannot be reached, please indicate a nearby person to contact.

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name of Physician _____ Phone _____

Name of Dentist _____ Phone _____

Are there any restrictions or limitations to activities? _____ No _____ Yes

Please list any developmental problems of your child _____

Allergies: _____ No _____ Yes (Identify)

Foods _____ Plants _____ Bee stings _____

Penicillin _____ Tylenol _____ Insect Bites _____

Other _____

Date of last Tetanus shot _____

Date of last Physical Exam _____

Does your child take regular medication _____ No _____ Yes

If yes, please identify _____

In case of an emergency and you cannot be reached, do you give permission for your child to be treated?

_____ No _____ Yes, (unless otherwise note, your child will be sent to UPMC Passavant Hospital) _____

Parent's signature _____ Date _____