The International Preschool of Warsaw
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MEDICAL QUESTIONNAIRE

(This form must be completed by a parent.)

Name of Child: _____ Date of Birth: _____

Local Address: _____

Phone Number: _____Email Address:_____

1. **Eyesight**: glasses_____ does not wear glasses_____
2. **Hearing**: normal_____ has some difficulty_____
3. **Respiratory**: Does the child suffer from any continuing difficulties such as asthma, hay fever, chronic chest cold?
   If so, please describe_____
4. **Allergies:** Please inform us of any allergies that your child has to common medications, insect stings, specific foods, etc.
   _____
   ____
5. Please list any other health problems: _____

_____

6. Does your child require medication for any long standing illnesses or allergies?
   _____
   If yes, please provide the type of medication and dosage
   _____
   _____

Signature of Parent/Guardian: _____
Date:_____