MEDICAL INFORMATION

(This form should be filled out by a physician and returned to the center before your child is enrolled.)

Child's Name _____ Birthdate _____

Address _____ Telephone _____

Parents' Names _____

Doctor's Name _____ Clinic Address _____

PAST HISTORY

IMMUNIZATIONS (Record date)

DPT

MMR

Poliomyelitis

Other

Are the immunizations up to date? _____ If immunizations are not complete, state the reason why.

Does the child have any allergies? _____

State the status of the following and note any specific problems.

Eyes: _____ Ears: _____

Throat: _____ Speech: _____

If the child has any important health problems, please state who is following the child _____. If the child has a specific health problem, please list anything special that the center should be aware of: _____

Date of last physical examination: _____

Date _____ Doctor's Signature _____