

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 _____