
2018-2019

Medical Information

Child's Name: _____

Date of Birth: ____/____/____

Class (2 or 3 day; a.m. or p.m.) _____

Parent(s) or Guardian(s): _____

Home Phone: _____ Mobile: _____

Street Address: _____ City, State, ZIP: _____

Doctor's Name: _____ Phone: _____

Doctor's Street Address: _____ City, State, ZIP: _____



Health information to be completed by the child's physician

Allergies: _____

On medication: _____

Vision difficulties: _____

Hearing difficulties: _____

Physical restrictions: _____

Concerns about speech or language development: _____

Is the child currently under medical treatment? ____ yes ____ no

If yes, state reason: _____

Are there any chronic conditions or recurring health problems not listed above that school personnel should know about? ____ yes ____ no

If yes, explain: _____

History: Has the child had any of the following:

- | | |
|----------------------|----------------|
| ____ Rheumatic Fever | ____/____/____ |
| ____ Measles | ____/____/____ |
| ____ German Measles | ____/____/____ |
| ____ Chicken Pox | ____/____/____ |
| ____ Whooping Cough | ____/____/____ |
| ____ Mumps | ____/____/____ |
| ____ Diabetes | ____/____/____ |
| ____ Epilepsy | ____/____/____ |
| ____ Other (specify) | ____/____/____ |

Immunizations: PLEASE ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORDS TO THIS FORM

Date: ____/____/____

Signature: _____ M.D.