2019-2020

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.