2020-2021

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.