MEDICAL INFORMATION

MUST BE COMPLETED BY THE PHYSICIAN

Name of Child: _____

Date of Birth: _____

IMMUNIZATIONS	Date/dose 1	Date/dose 2	Date/dose 3	Date/booster	Date/booster
DPT/DTaP	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____
MMR	_____	_____			
HIB	_____	_____	_____	_____	
HepB	_____	_____	_____		
VARICELLA	_____				
TB TEST	_____				
PCV	_____	_____	_____	_____	
HepA	_____	_____			
OTHER: _____	_____	_____	_____	_____	_____

Allergies: Yes No

If Yes, explain: _____

All Food Allergies – Must be accompanied by an Emergency Plan

Does this child have any other medical conditions that should be mentioned (such as asthma, hay fever, premature birth, developmental delays, etc.)? Yes No

If Yes, explain: _____

_____

Does this child require a hearing aid? Yes No

Does this child require glasses? Yes No

DOCTOR STATEMENT: I have examined this child within the past year and find that he/she is physically able to take part in preschool.

_____ _____

Physician's Signature Date

_____ _____

Print Physician Name Physician Phone Number

_____ _____

Address City, Zip

*** All children enrolled in God's Garden Preschool that are four years of age by September 1st are required by Chapter 36 of the Health and Safety Code to be screened for possible vision and hearing problems within 120 days of admission. God's Garden Preschool will provide screening services during the 1st semester of school, at the expense of parents, or parents may present evidence of screening conducted by their pediatrician.*