

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: _____

Hearing Exam Results: Does this child require a hearing aid? Yes No

Right Ear 1000 HZ _____ 2000 HZ _____ 4000 HZ Pass _____ Fail _____
Left Ear 1000 HZ _____ 2000 HZ _____ 4000 HZ Pass _____ Fail _____

Vision Exam Results: Does this child require glasses? Yes No

Right Eye 20/ _____ Left Eye 20/ _____ Pass _____ Fail _____

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.