CHILD HEALTH RECORD

This report is to be filled out by a licensed physician, physicians assistant, or nurse practitioner who has seen the child in the last twelve months and turned in to your child's teacher.

Child's Name _____ Sex _____ Birth date _____

Address _____

Past illnesses (Check those the child has had and give approximate dates):

Chicken Pox ☐ Rubeola ☐ Rubella ☐ Rheumatic Fever ☐
Asthma ☐ Hay Fever ☐ Diabetes ☐ Whooping Cough ☐
Poliomyelitis ☐ Epilepsy ☐ Mumps ☐ Other ☐

This child is ☐ is not ☐ physically or emotionally able to participate in the preschool program named above. Comments: _____

_____

Surgery/accidents/illnesses/chronic or handicapping problems: _____

_____

Describe any physical condition requiring special attention by preschool staff:

_____

Medication(s) prescribed: _____

Allergies that staff should be aware of _____ and prescribed routine: _____

Dental: _____ _____ _____
No visible decay *Decay present* *Exam Recommended*

Child's Dentist: Name: _____
Street Address: _____
City/State/Zip: _____ Phone: _____

If tuberculin test given: Date: _____ Result: _____
Vision Screening: _____ Hearing Screening: _____

Date of my most recent examination of child: _____

_____ _____
Signature of licensed physician, physicians assistant, or nurse practitioner *Date*

Please print name and address: _____
_____
_____