Shadyside Presbyterian Church Nursery School
5121 Westminster Place, Pittsburgh, PA 15232 ● www.shadysideschool.org ● 412-681-6311

CHILD MEDICAL INFORMATION

Child's Full Name_____ Date of Birth_____

Address_____

Parents' Names_____

Home Phone:_____ Cell Phone(s)_____

Please attach a copy of the child's immunization records.

Does child have any food or medication allergies ☐ Yes ☐ No **If yes, please provide emergency plan**
Please specify: _____

Please list any medications prescribed to the child: _____

List any health problems or special needs and recommended treatment/services. Attach additional sheets if necessary to describe care plan. _____
_____

In your assessment, is the child able to participate in nursery school? ☐ Yes ☐ No
If no, please explain: _____

Does the child appear to be free from contagious or communicable diseases? ☐ Yes ☐ No
If no, please explain: _____

Has the child received all age appropriate screenings listed in the Routine Preventive Health Care Services currently recommended by the American Academy of Pediatrics? ☐ Yes ☐ No

Note below the results of vision, hearing or lead screenings. If abnormal, provide date of screening, information about referrals, implications or actions recommended for nursery school participation.

Screening type	Date	Result/recommendations
Vision		
Hearing		
Lead		

_____ _____
Medical Care Provider Name Telephone

_____ _____ _____ _____
Address City State Zip

_____ _____
Signature of Physician, CRNP or Physician's Assistant Title

_____ _____
License Number Date signed