MEDICAL INFORMATION FORM (To be filled out by physician)

CHILD'S NAME	DATE OF BIRTH	DATE OF EXAMINATION

☐ The above named child was examined and found to present no hazard from contagious and communicable disease and is in good general health.

IMMUNIZATIONS (Include All Dates)

DPT	1st	2nd	3rd	BOOSTER	BOOSTER
ORAL POLIO	1st	2nd	3rd	BOOSTER	BOOSTER
MEASLES	DATE	RUBELLA	DATE	MUMPS	DATE

LEAD SCREENING	HIB VACCINE
DATE	DATE

TUBERCULIN TEST (Optional)

TYPE	RESULT

GIVE SPECIFICS FOR ALL YES RESPONSES AT RIGHT

		SPECIFICS
1. Are there allergic problems?	☐ YES ☐ NO	
2. Are there allergies to drugs?	☐ YES ☐ NO	
3. Is medication regularly taken? (If yes, specify drug and condition)	☐ YES ☐ NO	
4. Are there any conditions requiring special attention?	☐ YES ☐ NO	
5. Are there any food restrictions? (If yes, specify diet and condition)	☐ YES ☐ NO	

6. TEETH	(CONDITION)		
7. HEARING TESTED	DATE	METHOD	RESULT
8. VISION TESTED	DATE	METHOD	RESULT

9. MENTAL GROWTH AND DEVELOPMENT	☐ Normal ☐ Abnormal	(IF ABNORMAL, DESCRIBE)
10. PHYSICAL GROWTH	☐ Normal ☐ Abnormal	(IF ABNORMAL, DESCRIBE)

LIST ANY SPECIAL RECOMMENDATIONS CONCERNING CHILD'S HEALTH (use reverse side if necessary)

PHYSICIAN'S SIGNATURE	PHYSICIAN'S NAME (Please type)