

Centenary Thru-the-Week School

Medical Form



Child's Name _____ Birth date _____

Address _____ Phone _____

General Appearance

Head:

Eyes:

Ears:

Nose:

Throat:

Adenoids:

Tonsils:

Heart:

Lungs:

Abdomen:

Extremities:

Congenital Malformations:

Sleeping Habits:

Convulsions:

Allergies:

Drug Sensitivity:

Immunization Record (please provide a copy of the immunization record)

Immunization	Date	Date	Date	Date	Date
DTP/DTaP/DT					
Polio					
Hib					
Hep B					
MMR					
Var					

Please add any significant medical history. _____

I recommend this child for preschool.

Yes

No

Physician's Signature _____ Date _____