PHYSICAL EXAMINATION/ MEDICAL RECORDS

Name of child:_____ Age:_____

Birthdate:_____Height:_____Weight:_____

Parents' Names:_____

Allergies – Food:_____

Treatment, if any:_____

Allergies – Pollen, Animals, Etc:_____

Treatment, if any:_____

I hereby give permission to the staff to administer already said treatment for my child's allergy.

Parent Signature:_____

Physical handicaps:_____

Restrictions, if any:_____

Shot and booster record (Date of last booster)

Rubella_____

DPT_____

Polio_____

Mumps_____

Chickenpox_____

TB test_____

Childhood diseases that your child has had:

Name	Date	Name	Date
_____Chickenpox	_____	_____3 Day Measles	_____
_____Mumps	_____	_____Scarlet Fever	_____
_____Measles	_____	_____Others	_____

In case of accident or serious illness, I request the school to contact me. If I can not be reached I hereby authorize the school to call the physician indicated below and to follow his/her instructions. I if it is impossible to contact the physician, the school may make whatever arrangements necessary.

Physician:_____Phone:_____

Dentist:_____Phone:_____

Parents' Signature_____Date:_____