



Custodial Information:

If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the child please explain below and attach a copy of appropriate documents. (Court Order).

In the event that a medical emergency occurs I authorize _____ to seek

 (name of school)
 emergency medical care for my child as deemed necessary by the Director.

_____	_____
Date	Signature

I have received the Information to Parents Statement.

_____	_____
Date	Signature

Note to Applicant: When submitting your application please bring the following documents for your child:

- o Social Security Card
- o Immunization Records
- o Birth Certificate
- o Proof of Address (Abbott Only)

For Center Use Only:

Date of Enrollment _____

Date of Enrollment Conference _____

Date of Withdrawal _____



Children's Health Record

Child's Name _____

Date of Examination _____

Part I : HISTORY (to be completed by parent or medical staff)

Has the child had any of the following conditions? If yes, during what year?

Measles _____

Mumps _____

Chicken Pox _____

Scarlet Fever _____

Whooping Cough _____

Polio Myelitis _____

Diphtheria _____

Diabetes _____

Rheumatic Fever _____

Hernia _____

Epilepsy _____

Otitis Media _____

Heart Disease _____

Convulsions _____

Pneumonia _____

Mental Retardation _____

Any physical handicaps? _____

Allergies _____



Child's Name: _____

Part II: RESULTS OF EXAMINATION (to be completed by physician)

Scalp _____	Heart _____
Eyes and Vision _____	Pulse _____
Ears and Hearing _____	Abdomen _____
Nose _____	Genitalia _____
Teeth and Mouth _____	Extremities _____
Throat _____	Reflexes _____
Neck _____	Rectum _____
Lymph Glands _____	Skin _____
Spine _____	Throat _____
Lungs _____	Other _____
Height _____	Weight _____

Please indicate any condition which might affect this child's performance at school or any condition of which the staff should be aware: (medical treatments, special requirements as to diet, rest, allergies, avoidance of certain activities and other care).

Recommendations:

The above named child has been given a routine medical examination and has been found to be free of infectious or contagious diseases.

Signature of physician: _____

Address: _____



Immunizations (Please list initial date and any boosters)

Vaccine Type	Disease Month/Year	Primary Series			Boosters		
		1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Diphtheria & Tetanus (DPT and/or Td)							
Polio – indicate Oral or Salk in corner box. Oral – If monovalent indicate type 1,2, 3 in corner box. Salk – acceptable if given after 12/31/67.							
Measles (live)							
Rubella							
Mumps							
Other (Specify)							

Other _____

