CHILDREN'S HOUSE PRESCHOOL

HEALTH RECORD

(TO BE COMPLETED BY YOUR PHYSICIAN)

CHILD'S NAME___________________________________SEX______BIRTHDATE______________

ADDRESS____

Past Illnesses – Check any child has had and give approximate dates:

Chicken Pox__________________ Rubella _______________ Rubella_________________

Rheumatic Fever______________ Asthma________________ Hay Fever_______________

Diabetes_____________________ Mumps________________ Epilepsy_________________

Whooping Cough______________ Poliomyelitis____________ Other____________________

This child is_____ is not _____ physically or emotionally able to participate in the preschool program named above.

Comments:____

Surgery/Accidents/Illnesses/Chronic or Handicapping Problems:_________________________________

____

Describe any physical condition requiring special attention by school staff: ________________________

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Medication(s) prescribed:____

Allergies that staff should be aware of ____and prescribed routine:____

If tuberculin test given: Date: ________________ Result:______________________________

If chest X ray taken: Date: ________________ Result: ______________________________

Vision_______________________________________ Hearing ______________________________

Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization

Date of my most recent examination of child:____

____ _________________

Signature of licensed physician or licensed nurse practitioner Date

Please print name and address:_______________________________________

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