First Kids MEDICAL FORM

Date _____

Child's Name _____ Date of Birth _____

Home Address _____ City_____ Zip _____

Mother's Work Number _____ Mother's Cell Number _____

Father's Work Number _____ Father's Cell Number _____

Doctor's Name _____ Doctor's Phone Number _____

Doctor's Address _____

Medical Information:
Check any of the following your child has had:

( ) Measles (any type)	( ) Chicken Pox	( ) Appendicitis	( ) Convulsions/Seizures
( ) Whooping Cough	( ) Prolonged High Fever	( ) Head Injury	( ) Acute Ear Infections
( ) Mumps	( ) Tonsillitis	( ) Asthma	( ) Rheumatic Fever
( ) Wears glasses	( ) Diabetes	( ) Allergies	( ) Wears hearing aids

Any Known Allergies _____

Does the child use an epi-pen? ____yes ____no If yes, PLEASE provided to the preschool.

Describe any existing illness _____

Has the child been admitted to a hospital during the last 12 months? _____

List any medication child uses on a continual basis _____

_____

Immunization record current ( ) Yes ( ) No

The above named child is now free of any infectious or contagious disease and is physically able to participate in a child care program.

Physicians Signature_____ **Date** _____

(July 2023)