



CHILD MEDICAL INFORMATION

Date _____

Name of Child _____ DOB _____

Name of child's physician: _____

Physician's Phone #: _____

Were there any significant prenatal or birth factors?

RH? Y / N

Premature? Y / N

Other: _____

What age did child...

Sit? _____ Crawl? _____ Walk? _____ Talk? _____

Is Speech normal?

Has your child had any of the following?

Allergy _____ Ear Infections _____ Epilepsy _____ Emotional Problems _____

Operations _____ Pneumonia _____ Recurrent Illnesses _____

Communicable Diseases:

Chicken Pox _____ Rubella _____ Measles _____ Whooping Cough _____

Polio _____ Mumps _____ Scarlet Fever _____

Serious Accidents, explain: _____

Is your child presently under medical treatment? Y / N

If yes, please explain

Parent Signature

Date

Thank you for taking time to fill out this form. I will help better acquaint us with your child.



CHILD MEDICAL INFORMATION

Date _____

Thank you for taking time to fill out this form. I will help better acquaint us with your child.