THIS FORM MUST BE COMPLETED BY YOUR CHILD'S PHYSICIAN

Children's Health Record

Child's Name: _____ **Date of Birth:_____**
Street Address: _____ **City: _____**
Parent or Guardian: _____ **Phone: _____**
Pediatrician's Name: _____ **Phone: _____**

Medical History:

Allergies:_____
ChronicIllnesses _____
Previous Surgeries _____
Disabilities _____

Does your child wear: **glasses _____** **contacts ____**
Hearing aid ___ **Orthopedic aid ____**
Braces/ retainer ____

Physical Examination

Date of Exam _____ **Age of Child _____**

Skin _____ **Heart_____**
Lymph Nodes _____ **Lungs_____**
Eyes _____ **Abdomen _____**
Ears _____ **Genitalia _____**
Nasopharnyx _____ **Skeleton _____**
Teeth and Mouth _____ **Other _____**

Note and unusual Findings

_____
_____
_____

Does this child have any health conditions that limit his/her activities in normal group child care settings, including sports?

_____
_____

If Yes, what modifications of normal activities would be necessary to accommodate the child?

_____
_____

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Y___ N____
Explain_____

Physician's Signature: _____ Date:_____