Centenary Thru-the-Week School

Medical Form

Child's Name_____ Birth date_____

Address_____ Phone_____

General Appearance

Head:

Eyes:

Ears:

Nose:

Throat: Adenoids: Tonsils:

Heart:

Lungs:

Abdomen:

Extremities:

Congenital Malformations:

Sleeping Habits:

Convulsions:

Allergies:

Drug Sensitivity:

Immunization Record (please provide a copy of the immunization record)

Immunization	Date	Date	Date	Date	Date
DTaP					
Polio					
Hib					
PCV					
MMR					
Hep B					
Var					

Please add any significant medical history. _____

_____

I recommend this child for preschool. ☐ Yes ☐ No

Physician's Signature_____ Date_____