

CHILD'S HEALTH STATEMENT

First Blessings Preschool
First Baptist Church
2645 LaFayette Road
Fort Oglethorpe, GA 30742
706-866-0232

Name of Child: _____ Date of Birth: _____

Medical History:

Measles _____ Mumps _____ Chicken Pox _____ Whooping Cough _____

Flu _____ Meningitis _____ Convulsions _____

Allergies (including foods) _____

Any Evidence of:

Hearing Loss _____ Vision Difficulties _____

Speech Difficulties _____

List Any:

Hospitalizations: _____

Operations: _____

Other Serious Illnesses: _____

+++++

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Immunizations (give dates):

DPT (or Dtap) _____ Tetnus _____ Mumps _____

Measles (Rubeola) _____ (Rubella) _____ Oral Polio Vaccine _____

All Immunizations are up to date: ____ Yes ____ No If no, indicate reason: _____

Is the child free of communicable disease: ____ Yes ____ No

List any medications taken regularly by child: _____

Other remarks regarding physical condition: _____

Signature of Physician: _____ Date: _____

Address of Physician: _____

Phone Number: _____