

Child's Health Record

Angels of Hope Preschool

(This report is to be filled out by a licensed physician, physician's assistant or nurse practitioner who has seen the child within the last 12 months.)

Child's Name _____ Sex _____ Birth date _____

Address _____

Past illnesses *(Check those the child has had and give approximate dates.)*

Chicken pox Rubeola Rubella Rheumatic fever
 Asthma Hay fever Diabetes Whooping cough
 Poliomyelitis Epilepsy Mumps Other

This child is is not physically or emotionally able to participate in the early childhood program named above.

Comments: _____

Surgery/accidents/illness/chronic or handicapping problems: _____

Describe any physical condition requiring special attention by ECP staff: _____

Medication(s) prescribed: _____

Allergies that staff should be aware of: _____

Prescribed routine: _____

Dental: _____

No visible decay Decay present Exam recommended

Child's Dentist: _____

Address: _____

Phone number: _____

Tuberculin test given: ___ Yes ___ No Date: _____ Result: _____

Vision screening: _____ Hearing screening: _____

Date of my most recent examination of child: _____

Signature of licensed physician, physician's assistant or nurse practitioner Date

Please print physician's name & address

(Adapted from *The Ultimate Guide to Forms for Early Childhood Programs.*)
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