Child's Medical Report

Child's name_____Date of birth_____

Parents' names_____

Home address_____

Medical History
(completed by parents)

1. Does the child have allergies? No ___ Yes ___ If yes, please describe._____

   _____

2. Is the child currently under a doctor's care? No___ Yes ___ If yes, for what reason?

   _____

3. Does the child take any continuous medication? No___ Yes___ If yes, what medication and for what condition?_____

4. Has the child had previous hospitalizations or surgical procedures? No ___ Yes ___ If yes, when and for what reason?_____

5. Does the child have any chronic disease or recurrent illness? No ___ Yes ___ If yes, please explain._____

6. Does the child have any physical disability? No ___ Yes ___ If yes, please describe.

   _____

7. Does the child have any mental or emotional disability? No___ Yes___ If yes, please describe._____

Parent's signature_____