

RIGHT START PRESCHOOL AT THE HEIGHTS

Please copy for your records and return to the school office immediately.

MEDICAL HISTORY

Date _____

Student's Name _____

Age _____ Birth Date _____ Sex _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____-_____

Father's/Guardian's Name _____

Work Phone (____) _____-_____

Mother's/Guardian's Name _____

Work Phone (____) _____-_____

Family Doctor _____

Phone (____) _____-_____

DATES OF IMMUNIZATIONS AND TESTS

DPT (baby shots)----- 1 _____ 2 _____ 3 _____

DPT Booster ----- 1 _____ 2 _____

Tetanus Boosters ----- _____

Oral Polio/IPV ----- 1 _____ 2 _____ 3 _____

Polio Booster ----- 1 _____ 2 _____

Measles Vaccine (9-day) _____

Rubella Vaccine (3-day) _____

Mumps Vaccine ----- _____

Measles Booster ----- _____

Hepatitis B ----- 1 _____ 2 _____ 3 _____

Tuberculin Test ----- _____ Result _____

Chest X-Ray ----- _____ Result _____

Varicella Vaccine (Chicken Pox) or date of disease:

HEALTH RECORD:

(Give dates if possible - may answer YES or NO)

Chicken Pox ----- yes _____ no _____ Dates _____

German measles (3-day) -- yes _____ no _____ Dates _____

Mumps ----- yes _____ no _____ Dates _____

Scarlet Fever ----- yes _____ no _____ Dates _____

Diabetes ----- yes _____ no _____ Dates _____

Whooping Cough ----- yes _____ no _____ Dates _____

Ear Problems/Tubes ----- yes _____ no _____ Dates _____

Tuberculosis ----- yes _____ no _____ Dates _____

Epilepsy ----- yes _____ no _____ Dates _____

Heart Disease ----- yes _____ no _____ Dates _____

Seizures or Convulsions yes _____ no _____ Dates _____

Rheumatic Fever ----- yes _____ no _____ Dates _____

Allergies ----- yes _____ no _____

List Allergies _____

Does your child wear glasses? yes _____ no _____

Measles (9-day) ----- yes _____ no _____

(Under Doctor's care?) yes _____ no _____

Asthma ----- yes _____ no _____

(Under Doctor's care?) yes _____ no _____

Other serious illness or handicap

Surgeries (type and Date)

Medications your child is presently taking?

Are there any restrictions to your child's physical
Activity?

(Use reverse side for details)

Parent/Guardian Signature