ST. JOHN'S EARLY LEARNING CENTER
CHILD HEALTH REPORT

This report is to be completed and signed by a licensed physician, and returned to school.

Child's Name_____ **Sex**___ **Birth Date**_____

Address_____

Date of most recent examination_____

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

Describe any physical condition requiring special attention by preschool staff_____
_____

Allergies, food restrictions, etc. that the staff should be made aware of_____**and prescribed routines**_____

Medication(s) prescribed_____

Based upon his/her medical history and physical condition at the time of this examination, is free from apparent communicable disease and is in suitable condition for enrollment in a child day care/preschool facility.

_____ _____
Physician's Signature ***Date***

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Number

CERTIFICATE OF IMMUNIZATION

Fill out in the form below, entering month, day and year of each immunization or attach a record of immunization as provided by the child's physician.

DTP 1._____ 2._____ 3._____ 4._____ 5._____

Polio 1._____ 2._____ 3._____ 4._____

The *5th DTP and the 4th Polio are normally administered prior to Kindergarten*

MMR 1._____

If given separately:
Measels_____Mumps_____Rubella_____

HIB _____

HEP b 1._____ 2._____ 3._____

Varicilla _____

This is to certify that (child's name)_____ has received the immunizations required by the state for admission to school.

_____
Physician's Signature

_____
Date