

CHILDREN'S DAY OUT PRESCHOOL

CHILD'S HEALTH RECORD

Name _____

Birthdate _____ Birthplace _____

Parent's Name _____ Address _____

Sex F M Phone _____

IMMUNIZATION RECORD

DATES GIVEN

DOSE	DTap DTP or DT	OPV or IPV	Td	Hepatitis B	Hib	MMR	MR
Dose No.1							
Dose No.2							
Dose No.3						Measles	Rubella
Dose No.4				HBIG			
Dose No.5						Mumps	Varicella
Dose No.6							
							Other

This is to certify that the above named child is free of communicable disease and is able to participate in the preschool activities. Please state if you recommend any modification in the school routine for this child or if you find evidence of allergies about which the school should know.

Physician's Recommendation _____

Physician's Address _____ Telephone Number () _____
(Street, City, State, Zip Code)

Signature of Physician or Registered Nurse Date Physician's or Nurses's Name (please print)
Under the Supervision of Physician

Name of Clinic, Group Practice, other

If Nurse is Supervised by Physician, Indicate
Physician's Name