

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