



**IMMUNIZATION SECTION (SEE OVER) ALSO MUST BE COMPLETED!**

Parent, guardian, or physician may complete this information.

GENERAL QUESTIONS (Explain "YES" answers below.)

BP \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

T B MANTOUX TEST/DATE OF LAST TEST \_\_\_\_\_

RESULT: \_\_\_\_ POSITIVE \_\_\_\_ NEGATIVE

PLEASE INDICATE DATE OF IMMI Mo./Yr. Mo./Yr. Mo./Yr. Mo./Yr. Mo./Yr.

Table with 6 columns for dates and rows for DTP, DT, German Measles, Mononucleosis, Mumps, Rubella, Hamophius influenza B, HEPATITIS B, Varicella (Chicken Pox), Polio.

Current treatment/Medications: Any Limitations:

Allergies: \_\_\_\_\_ None \_\_\_\_\_ Yes (List): \_\_\_\_\_

Additional Health Information \_\_\_\_\_

Recommendations/Restrictions while at program:

Does the child have a bronchial inhaler, bee sting kit, epi-pen or other health related device?

Medication(s) to be administered (Includes dosages and times of administration);

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

To the best of my knowledge, there \_\_\_\_\_ is \_\_\_\_\_ is not, a medical contraindication to administering acetaminophen (Tylenol).

Child's Licensed Physician's Name (Please Print): \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of completion of this form \_\_\_\_/\_\_\_\_/\_\_\_\_

Please Note: We do not administer any medications on site.

I hereby attest that the information on both side of this form is correct.

Guardian/Parent/Physician Signature

Date