BS"D

TORAH TOTS PRESCHOOL
MEDICAL INFORMATION FORM
(MUST BE FILLED OUT BY A MEDICAL DOCTOR)
PLEASE ATTACH A CURRENT IMMUNIZATION RECORD

Child's Name________________________________ Date of Birth _______________

Family Doctor ____ Phone ______________________

Health Insurance Company _______________________________ Policy Number ______________

PREVIOUS ILLNESSES	**Year of Illness**
Asthma, Hives, Eczema	___________
Chicken Pox	___________
Diabetes	___________
Ear Infections	___________
Epilepsy	___________
German Measles	___________
Measles	___________
Mumps	___________
Rheumatic Fever	___________
Scarlet Fever	___________
Tonsillitis	___________
Whooping Cough	___________

Food and/or Drug Allergies:____

____

Is this child currently taking prescribed medication? Yes □ No □

If yes, please list the medications and the reason for taking________________________________

____

Is there any reason that this child cannot be immunized? ___________________________________

____

Operations or Hospitalizations: ____

____

Are there any problems that restrict this child's activities? Yes □ No □

If yes, please explain: ____

Does this child have any special problem or condition which this school would be unable to handle?

Yes □ No □ If yes, please explain: ____

Results of Examination: ____

Signature of Physician or Health Agency Representative ___________________________________

Date of Pre-admission Physical Exam: ____