



MEDICAL INFORMATION FORM

This form must be completed by a physician and returned to Little L.A.M.B.S. Preschool as a part of the enrollment process.

CHILD'S NAME _____ DATE _____

BIRTHDATE _____ AGE _____

ADDRESS _____

PARENT'S NAMES _____

PHYSICIAN'S NAME _____

ADDRESS _____ PHONE _____

PAST HISTORY

Does child have any allergies? _____ If yes, list and explain any measures needed to
Care for child _____

Does child have any other important or specific health problems? If yes, list, and give
physician's name who is treating and explain any measures that the preschool should be
undertaking.

State the status of the following and note any specific problems.

Eyes: _____ Ears: _____

Throat: _____ Speech: _____

Summary of admissions to hospitals (record date and physician) _____

Date of last physical examination: _____

Summary of findings and recommendations: _____

Date of next physical examination: _____

Date _____ Physician's signature _____