MEDICAL RECORD

Name of Child: _____ Date of Birth: _____

Mother's Name_____

Address _____

Home Phone Number _____ Work Phone Number_____

Cell Phone _____ E-mail Address: _____

Father's Name_____

Address_____

Home Phone Number _____ Work Phone Number_____

Cell Phone _____ E-mail Address: _____

Physician's Name_____

Address _____

Phone Number _____

Insurance Information _____

Child's Medical Record Number _____

Chronic Illnesses _____

Allergies _____

Current Medications _____

_____

Special Information:

_____

_____

Please note: Complete Immunization records must be on file prior to your child's first day of enrollment.