Name_____ Date_____

Date of last medical examination_____

Does child have or has child ever had: Yes   No

    Anemia........................   _____   _____

    Diabetes......................   _____   _____

    Hepatitis ....   _____   _____

    Allergies ....   _____   _____

       To penicillin ....   _____   _____

       To local anesthetic ....   _____   _____

    Abnormal heart condition ....   _____   _____

    Abnormal bleeding from a cut ....   _____   _____

    Rheumatic fever ....   _____   _____

    Heart murmur ....   _____   _____

    Is your child under the care of a physician now_____   _____

    Is any medication being taken now ....   _____   _____

    If so, what_____

_____

Other physical conditions _____

_____

Name of physician_____ Phone number_____

Information given by (signature)_____

For reminder calls, should we contact you by:

Phone#_____Text#_____Email_____