CHILD'S HEALTH RECORD

FBC Preschool Early Education Center
1200 9th St.
Wichita Falls, TX 76301
Fax (940) 766-1373

**<u>This form must be completed and signed by a health care provider.</u>

Name of child ________________________________Birth date _________________

Height __________________Weight _________________

Is there a medical reason why immunizations cannot be given? Yes _____ No _____

If yes, please explain____

Are all immunizations up to date? Yes _______ No ________

If no, please indicate reason ____

Please attach a copy of immunization records to this form.

<u>GENERAL INFORMATION</u>

Does child have any known allergies? ____

Please list any medications the child is taking of which school staff should be aware:

____

Does child have any special needs of which staff should be aware?

____

The above information is correct as of this date: _______________________

Signature of Physician ___________________________

Please print Physician's name ______________________

Address: ______________________________________

Telephone:_____________________________________

*******Please attach a copy of the child's shot record*******