

DAVIDSON COLLEGE PRESBYTERIAN CHURCH
WEEKDAY PRESCHOOL
PO Box 337 Davidson, NC 28036
704-892-5641 fax: 704-892-5956

HEALTH FORM
(to be completed and signed by the child's physician)

Name of child: _____

General physical condition: _____

Operations: _____

Serious Accidents: _____ Dates: _____

Serious Illness _____ Dates: _____

Allergies: _____

Are there any usually frequent problems (ear infections, etc.) ? _____

Condition of teeth: _____

Is there any special medical situation of which the school should be aware (emotional, behavior, hearing, vision, muscular, etc.)?

Date of last examination _____ Date of last TB test: _____

IMMUNIZATIONS (vary by age)

DPT _____

POLIO _____

MMR _____

HIB _____

HEP B _____

VARIVAX _____

I certify that the above named child received the listed vaccines on these dates and is up-to-date on his/her immunizations.

Date: _____ Physician's Signature _____

Address: _____