



FIRST ASSEMBLY OF GOD CHILD DEVELOPMENT CENTER

MEDICAL STATEMENT FOR ADMISSION

Child's Name: _____ Sex: _____

Child's Date of Birth: _____

Child's Physician: _____ Phone: _____

MEDICAL HISTORY

<u>Illnesses</u>	<u>Y/N</u>	<u>Age</u>	<u>Illnesses</u>	<u>Y/N</u>	<u>Age</u>
Chicken Pox	_____	_____	Pneumonia	_____	_____
Influenza	_____	_____	Rheumatic Fever	_____	_____
Measles	_____	_____	Scarlet Fever	_____	_____
Rubella(3 day)	_____	_____	Whooping Cough	_____	_____
Mumps	_____	_____	Epilepsy	_____	_____
Tuberculosis	_____	_____			

Past Surgeries: _____

Past Illnesses: _____

Physical Handicaps: _____

PHYSICAL EXAMINATION

Temp ____ Pulse ____ Resp ____ Hgt ____ Wt ____ Heart ____ Chest ____ Throat ____

Abdomen ____ CE ____ Ext ____ Neurological System ____

Teeth ____ He ____ Skin ____ Eyes ____ Ears ____

Should activity be limited? _____

Allergies or other restrictive conditions: _____

Date of Examination: _____

Physician _____

Phone _____

Address _____