PRESCHOOL HEALTH SERVICES RECORD

(Filled out by Parent or Guardian)

DATE: _____ SCHOOL: PROMISED FUTURE NURSERY SCHOOL

NAME: _____ _____
(SURNAME) (GIVEN)

SEX: M ____ F ____ DATE OF BIRTH _____/_____/_____
Day month year

NAME OF PARENT OR GUARDIAN _____

HOME TELEPHONE # _____ BUSINESS TELEPHONE # _____

IMMUNIZATION HISTORY

VACCINES

PLEASE FILL OUT IN FULL OR ATTACH A COPY OF UPDATED MEDICAL RECORD

DIPHTHERIA	_____	_____	_____	_____
PERTUSSIS	_____	_____	_____	_____
TETANUS	_____	_____	_____	_____
POLIO INJECTED	_____	_____	_____	_____
POLIO ORAL	_____	_____	_____	_____
MEASLES	_____	_____	_____	_____
MUMPS	_____	_____	_____	_____
RUBELLA	_____	_____	_____	_____
HEMOPHILUS B.	_____	_____	_____	_____ **OR** SE

ATTACHED COPY FROM YELLOW CARD

PLEASE CHECK IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING COMMUNICABLE DISEASES

RED MEASLES _____ GERMAN MEASLES (RUBELLA) _____ MUMPS _____
HEPATITIS _____ WHOPPING COUGH (PETUSSIS) _____

DOES YOUR CHILD WEAR ANY APPLIANCE SUCH AS HEARING AID, BRACE, ETC.? _____ YES _____ NO
Please Explain:
_____

HAS YOUR CHILD HAD ANY EAR PROBLEMS SUCH AS "TUBES" PUT IN THE EARS? _____YES _____NO
Please Explain:
_____

IS THERE ANY PRESENT HEALTH PROBLEM? _____YES _____NO
Please Explain:
_____

IS YOUR CHILD TAKING ANY REGULAR MEDICATION INCLUDING ALLERGY INJECTIONS?
_____YES _____ NO Please Explain: _____
_____

SIGNATURE _____
(Parent or Guardian)

September 1, 2020