BRIGHT BEGINNINGS CHRISTIAN PRESCHOOL
Medical Form

Child's Name _____

Pediatrician's Name _____

Pediatrician's Phone _____

Pediatrician's Address _____

Hospital Preferred _____

Health Insurance Carrier _____

Policy Number _____

Please list all allergies and indicate severity: _____

_____

_____

Please describe any food restrictions: _____

_____

_____

Please list any physical, medical, or mental conditions that may affect your child's time at preschool:

_____

_____

_____

Please list the dates of your child's most recent immunizations (or obtain and attach a copy of your child's immunization record from his/her pediatrician):

VACCINE		DATE
HepB	(hepatitis A)	
RV	(rotavirus)	
DTaP	(diphtheria, tetanus, pertussis)	
Hib	(Haemophilus influenzae type b)	
PCV	(pneumococcus)	

VACCINE		DATE
IPV	(polio)	
MMR	(measles, mumps, rubella)	
Varicella		
HepA	(hepatitis A)	
other	_____	

_____ _____

Parent/Guardian signature Date