WELLNESS RECORD FORM

Child's Name _____ Birthdate _____

Address _____ Phone # _____

Below Information Must Be Completed by Child's Physician

Health Information

General Condition of Health: _____

_____

Vision normal? Y / N If not, does child need corrective lenses? _____

Hearing difficulties? Y / N Explain: _____

Does child have allergies? _____

Prescribed medications: _____

Is the child receiving treatment for a chronic illness? ____Yes ____No

If so, what is the diagnosis? _____

What is the prognosis?_____

List any emotional, mental health, or physical conditions of the patient that could adversely affect the child or others while in our care.

_____

_____

Other comments/recommendations to school personnel:

_____

_____

Physician's Statement

The child identified above was examined by me on: _____ and was found to be free of any infection or contagious disease and may be admitted to a child care facility where s/he will be placed with other children in group situations.

Doctor's Name: _____

Name of Practice: _____

Doctor's Signature: _____

Attach to this form:

____ Immunization Card (if new student) ____ Any new immunizations given (if continuing student)

Fax to: Orchard Valley Learning Center | 303.690.7193