

Date of Last Examination: _____

IMMUNIZATION: (Last date given)

Polio_____Tetanus/Diphtheria_____Measles_____

Rubella_____Mumps_____

CHRONIC/RECURRING CONDITIONS: (Check any that apply)

Seizure Disorders_____Diabetes_____Fainting_____

Heart Disease_____Kidney Disease_____Nosebleeds_____

Headaches_____Asthma/Respiratory Problems_____

ALLERGIES: (Check all that apply; be specific. If no allergies, leave empty)

_____Animal_____

_____Food_____

_____Insect Bites_____

_____Plants_____

_____Pollen_____

_____Medicines/Drugs_____

_____Other_____

May be given Tylenol? YES NO

May be given cough drops? YES NO

Emergency Contact: _____

Emergency Number: _____

Cell number: _____

Relationship to child: _____

Parent/Guardian Signature

Date

Notary Information:

_____ has signed before me

on the _____ day of _____ 20_____

Notary's name

Signature of Notary

Notary Stamp