

Concord University Child Development Center
P.O. Box 1000 D-135, Athens, WV. 24712
304-384-6335

Child's Medical History

Date of Examination _____

Child's Name _____ DOB: _____

Parent's Name _____

Previous or Past Illnesses

___ Measles Allergies _____

___ Mumps

___ Chicken Pox Foods/Products child should avoid _____

___ Pneumonia

___ Colds Ongoing Medications _____

___ Ear Problems

___ Convulsions Activity/Physical Limitations _____

___ Rheumatic fever

___ Scarlet Fever Past hospitalizations/Serious illness _____

___ Diabetes

Other illnesses _____

Premature Birth Yes No

Height: _____ Weight: _____ Heart Rate: _____ BP: _____

Immunizations (Fill in the Dates Received)

Hep B 1. _____ 2. _____ 3. _____

DTaP 1. _____ 2. _____ 3. _____ 4. _____

Hib 1. _____ 2. _____ 3. _____ 4. _____

Polio 1. _____ 2. _____ 3. _____

MMR 1. _____

Varicella 1. _____

Pevnar 1. _____ 2. _____ 3. _____ 4. _____

PPD 1. _____ Neg/Pos _____ 2. _____ Neg/Pos _____

If immunization program is not complete, please indicate a schedule for its completion.

The child is within normal limits of development and is able to participate in a group care program.

Physician's Signature

Date