BETHANY CHRISTIAN PRESCHOOL/
MOTHER'S MORNING OUT
PHYSICAL EXAMINATION FORM

NAME OF CHILD _____

DATE OF BIRTH_____

IMMUNIZATION (DATE OF LAST BOOSTER SHOT)

DIPHTHERIA_____ TETANUS_____

PERTUSSIS_____

POLIO_____

MMR_____ OTHERS_____

VARICELLA_____

COMMUNICABLE DISEASES ALREADY HAD:

ALLERGIES:

_____

_____

PHYSICAL DEFECTS (SIGHT, HEARING, HEART):

_____

_____

COMMENTS:_____

_____

SIGNATURE OF PHYSICIAN_____DATE _____

PHYSICIAN'S NAME (please print) _____

PHYSICIAN'S TELEPHONE # _____