EARLY RESULTZ
Daycare & Learning Center

# Medical Information

Child's Name _____

Birth Date _____ (MMDD/YYYY) Sex_____

Child's Social Security Number _____ _____ _____

**Medical History**

Diseases: _____

Check all that apply:

Asthma _____ Pneumonia _____

Chicken Pox _____ Whooping Cough _____

Heart Disorder _____ Diphtheria _____

Measles Mumps _____ Rubella Other _____

Congenital Malformations

_____

Allergies (drug, food, etc.)

_____

Drug Sensitivities

_____

Seizures _____

Comments

_____

Parent's Signature: _____Date:_____

Address _____Phone # _____