Children's Medical Report

vame of Child					Birthdate	
Name of Parent o	r Guardian_					
Medical Histor	y (May be co	ompleted by p	parent)			
Is child allergic	to anything?	NoYes_	If yes, wha	t?		
Is child currentl	y under a doc	ctor's care? No	o Yes	If yes, for wh	nat reason?	
Is the child on a	ny continuou	s medication?	NoYes_	If yes, wh	nat?	
Any previous ho	spitalization	s or operation	s? NoYes	s If yes, w	hen and for what?	
Any history of s convulsions No If others, what/v	Yes;	heart trouble	NoYes_	_; asthma N	Yes; diaber	tes NoYes;
Does the child h	ave any phys	sical disabilitie	es: No Ye	s If yes, p	lease describe:	
	ities? No	ian				Date
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