

**SCHOOL HOUSE CHRISTIAN PRESCHOOL
CHRIST LUTHERAN CHURCH OF LOWER SAUCON
P.O. BOX 153, HELLERTOWN, PA 18055 610-838-7370**

Full Name of Child: _____

Date: _____
Last First Middle

Birth date: _____ **Gender:** _____

Address:

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

<i>Enter month, day and year each immunization was administered</i>							
VACCINE DOSES BOOSTERS & DATES							
Diphtheria & Tetanus*	1.	2.	3.	4.	5.		
Polio	1.	2.	3.	4.	5.		
Measles, Mumps, Rubella	1.	2.					
Hepatitis B	1.	2.		3.			
HIB	1.	2.		3.			
Chicken Pox							
Other							
*Tetanus and Diphtheria are usually received in combined vaccines such as DPT, DT or Td							
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <p><u>Medical Exemption</u> <i>The physical condition of the above named child is such that immunization would endanger life or health.</i></p> </td> <td style="width: 50%; border: none; vertical-align: top;"> <p><u>Religious Exemption</u> <i>Include a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian.</i></p> </td> </tr> </table>						<p><u>Medical Exemption</u> <i>The physical condition of the above named child is such that immunization would endanger life or health.</i></p>	<p><u>Religious Exemption</u> <i>Include a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian.</i></p>
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Significant Medical Conditions (please check off)			
YES	NO	If YES,	
Explain			
Allergies			
Asthma			
Cardiac			
Coordination Difficulties (i.e. stumbling, falling)			
Diabetes			
Gastrointestinal Disorder			
Hearing Disorder			
Significant Medical Conditions (please check off)			
YES	NO	If YES,	
Explain			
Hypertension			
Neuromuscular Disorder			
Orthopedic Condition			
Respiratory Illness			
Seizure Disorder			
Skin Disorder			
Speech Difficulties			
Vision Disorder			
Other (please specify)			
Daily Medication(s) administered to your child and reason(s)			

Did you conduct a physical examination? _____ Yes _____ No

The physical examination should include a functional assessment of vision, hearing, and a systems review. Please list any communicable diseases or any condition that might endanger the health/welfare of other children or adults in the preschool setting.

Date of Examination:
Printed Name of Examiner:
Signature of Examiner:
Print complete address and telephone number of Examiner: