First Metropolitan Infant Development Center & Christian Academy

CHILD'S HEALTH RECORD

Child's Name:	Date of Birth:

Health Requirements for Children:

1. Evidence must be presented for each child upon entering care that he/she is physically able to take part in our program.
2. At the beginning of each school year thereafter, evidence must be presented that the child continues to be able to participate in our program.
3. **A current immunization record for each child must be maintained at our facility.** When your child's receives additional doses or boosters, you must update his/her record immediately. These records are audited regularly by Texas Department of Health.

Admission Requirement:

One of the following must be presented when your child is admitted to our facility. Please check the option that applies.

_____ A written statement from licensed physician, signed and dated, certifying that the physician has examined your child within the past year and that the child is physically able to take part in our program.

_____ "I have examined the above-named child within the past year and find that he/she is physically able to take part in your program.

_____

Physician's Signature Date

_____ A signed and dated copy of a health care professional statement is attached

_____ My child has an appointment for a physical examination on _____ with _____.

_____

Physician's Address and Phone Number

I will submit the physician's statement immediately following the examination

_____

Signature of Parent or Legal Guardian Date

Note: If medical diagnosis and treatment and/or immunization conflict with your religious belief you must sign a notarized affidavit to the effect and attach it to this form. If immunization would be injurious to your child or family, you must obtain a certificate signed by a physician to that effect and attach it to this form.

General state of health: _____

_____

Are your child's immunizations up to date? _____ (Please attach a copy of immunizations. This should include the signature of nurse or doctor who administered medications.)

Does your child have any known allergies?

_____

_____

_____

Are you concerned that your child may be prone to any type of allergies? Please describe:

_____

_____

_____

Does your child have any medical conditions which I should be made aware of?

_____

_____

_____

Has your child had the following common childhood illnesses? *Circle all that apply*

Chicken Pox:	Yes	No
Measles:	Yes	No
Whooping Cough:	Yes	No
German Measles:	Yes	No
Mumps:	Yes	No

Other: _____

Is your child prone to any of the following?

Ear Infections:	Yes	No
Headaches:	Yes	No
Stomach Upsets:	Yes	No

Does your child have any speech, hearing or visual problems?

_____

_____

Has your child ever been tested for the above?

_____

_____

Has your child ever had any surgeries or do they have any prosthetic limbs etc.? If yes, please describe:

_____

_____

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