Daydreams Childcare Center

Medical Record

Name of Child:_____Birthdate:_____

Parent's Name:_____ Phone:_____

Family Doctor:_____ Phone:_____

Has the Child had:	Measles	☐	Chickenpox	☐
	Whooping Cough	☐	Other	☐
Any History of:	Skin Conditions	☐	Ear Infection	☐
	Asthma	☐	Bronchitis	☐
	Pneumonia	☐	Convulsions	☐

Any special treatment necessary? Yes ☐, _____ No ☐

Immunizations (Give Dates):

- (2 months) Polio/Whooping cough: _____
- (4 months) Polio/Whooping cough: _____
- (6 months) Polio/Whooping cough: _____
- (12 months) Measels, Mumps, and Rubella: _____
- (18 months) Whooping cough/Polio: _____
- Other (chicken pox) _____

I hereby certify that _____ is/is not free from communicable diseases.

_____(Doctor/Parent signature)