ESU #8 Preschool Health Physical Form

Name	School	
Address	Date of Birth	
Parent/Guardian	Phone cell	home

Immunizations	Month/Day/Year	Given By
DTaP/DTP/TD (Diptheria - Tetaus - Pertussis)	1	
	2	
	3	
	4	
	5	
	6	
Polio (IPV,OPV)	1	
	2	
	3	
	4	
	5	
MMR (Measles, Mumps, Rubella)	1	
	2	
Hepatitis B	1	
	2	
	3	
Varicella	1	
	2	
HIB	1	
	2	
Other		

Medical History	Yes	No	Comments
Allergies			
Asthma			
Diabetes			
Glasses/Vision Difficulties			
Head Injury			
Hearing Loss or Difficulties			
Heart Problems			
Orthopedic Problems			
Seizures			
Surgery			
Other	Current Medications/Dose/Reason		

I give my consent to share this information with school personnel.

Parent Signature

Date