

**HIGHLAND PARK UNITED METHODIST CHURCH
CHILD DEVELOPMENT PROGRAM
MEDICAL INFORMATION FORM**

Child's Name _____ **Birth Date** _____ **Age**

Home Address **Height** (no shoes) _____
Weight (light clothing) _____ **lbs.** _____ **oz.**

Child's Physician _____ **Address** _____ **City/State/Zip** _____ **Phone**

Hospital of Choice _____ **Address** _____ **City/State/Zip** _____ **Phone**

**Parents – Please have your child's physician complete the following information.
(This information must be returned by your child's first day of attendance at the CDP.)**

Results of Vision Screening (required of 4-year-olds and older children) _____

Results of Hearing Screening (required of 4-year-olds and older children) _____

Diagnosis of physical or mental impairment: _____

Limited activities (List activities in which child should not participate.) _____

Medication prescribed on a regular basis (must be in original container if administered at facility):

Special dietary needs: _____

Allergies: _____

Serious illness, injury or hospitalization during the past 12 months: _____

Physician's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.

Physician's Signature

Date

Parent's Signature

2007-2008

Date

Please return the signed and dated form to the CDP along with a copy of your child's most recent immunization record and/or have your child's physician's office complete the immunization record on the reverse.