# 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**

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**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** _____ **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.**