GREEN MOUNTAIN VILLAGE PRESCHOOL
HEALTH CERTIFICATE

This form required for registration. Must be filled out and signed by your physician.

Child's Name: _____ Sex: _____ Date of birth: _____

Address: _____

Past illnesses - check those the child has had and give approximate dates:

Chicken Pox _____ Rubella _____ Hay Fever _____
Rheumatic Fever _____ Asthma _____ Epilepsy _____
Diabetes _____ Mumps _____ Other _____
Whooping Cough _____ Poliomyelitis _____

Comments: _____

Surgery/Accidents/Illnesses/Chronic Health Problems: _____

_____

Describe any physical condition requiring the facility's special attention: _____

_____

Medication(s) prescribed: _____

_____

Allergies: _____ and prescribed routine: _____

If tuberculin test given: Date: _____ Result: _____

If chest X - ray taken: Date: _____ Result: _____

Vision: _____ Hearing: _____

Please record immunizations and dates administered on the Colorado Department of Health Certificate of immunization and attach to this form.

Date of my most recent examination of this child: _____

_____ _____
Signature of licensed physician or other health care professional Date

Please Print: _____
Name of Physician/Health Care Professional

_____
Address City State Zip

_____
Phone