

**CEDARVILLE NURSERY SCHOOL**

1092 Laurelwood Road

Pottstown, PA 19465

610-970-9557

**MEDICAL FORM**

Name of child: \_\_\_\_\_

has been examined by me and found to be in good health and able to participate in all activities at Cedarville Nursery School.

Immunization Record (date of last shot or booster):

DPT \_\_\_\_\_ Polio \_\_\_\_\_ MMR \_\_\_\_\_

HIB \_\_\_\_\_ Varicella \_\_\_\_\_ Hepatitis B \_\_\_\_\_

Other \_\_\_\_\_

Allergies: \_\_\_\_\_

History of Communicable Diseases

\_\_\_\_\_  
\_\_\_\_\_

Physical Defects

\_\_\_\_\_  
\_\_\_\_\_

Physical/social/behavioral problems

\_\_\_\_\_  
\_\_\_\_\_

Comment: (please note any limitations)

\_\_\_\_\_  
\_\_\_\_\_

Medications taken regularly:

\_\_\_\_\_

\_\_\_\_\_ M.D.

\_\_\_\_\_ Date  
(Needs physician's signature or stamp)