

Year of last immunization:

DPT _____

DPT Booster _____

Tetanus Booster _____

Polio Booster _____

Polio Series _____

Operations or Serious injury (describe) _____

Allergies (please check all that apply):

Hay Fever

Asthma

Fainting

Poison Ivy

Sulfa

Convulsions

Penicillin

Bee Sting

Aspirin

Other

I give my child permission for Tylenol or Ibuprofen to be administered to my child. yes no

Present Medical problems: _____

If any of the above are yes, explain the treatment and/or medications needed. Medication will be dispensed by the adult staff:

Health Insurance Co _____ Policy No. _____

Doctor's Name _____ Phone No. _____

I hereby certify that the above information is correct.

Parent Signature: _____ Date: _____

Notary: _____

(Name)

(Commission expires)

Notary Seal: