Health

Child's Name ______________________ Birthday ______________________

Home Address ______________________ Phone ______________________

Parent's Name ______________________

Physician's Name ______________________ Phone ______________________

Physician's Address ______________________

IMMUNIZATIONS

Vaccine	Date Series				Date	
	1st	2nd	3rd		Last Booster	
DPT						
Polio						
HibCV						
Chicken Pox						
Hepatitis B						

Measles ______________________ Date ______________________

Mumps ______________________ Date ______________________

Rubella ______________________ Date ______________________

TB Skin Test ______________________ Neg. ____________ Pos. ____________

Has this child ever experienced a blood transfusion? Y/N
B Type:

GENERAL HEALTH

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Visual acuity L R	Hearing acuity L R

Does the child have any chronic medical conditions necessitating dietary restrictions or supplements, medication, avoidance of allergies, or restrictions upon normal activity? If so, please explain:

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PHYSICIAN & PARENTS STATEMENT

The above named child bas been examined by a licensed physician within the past year and is physically able to participate in the full program of Crème de la Crème.

Mother or guardian X ______________________ Date ______________________

Father or guardian X ______________________ Date ______________________

Physician X ______________________ Date ______________________