



# HIS KIDS PRESCHOOL

## ~Health Record~

538 Park Ave, Reading, PA 19611 610-372-1962

This document must be on file within thirty days from the first day of class.

*His Kids Preschool admits students of any race, color, and national or ethnic origin.*

Child's Name: \_\_\_\_\_  
last first middle sex date of birth

Address: \_\_\_\_\_  
street city zip telephone

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

**IN EMERGENCY NOTIFY:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**If above person can not be notified,**

**call:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

Family Physician: \_\_\_\_\_  
name address telephone

Family Dentist: \_\_\_\_\_  
name address telephone

Is your child on daily medication(s)? \_\_\_\_\_  
If yes, state type and purpose. \_\_\_\_\_

Does your child have any restrictions? \_\_\_\_\_  
If yes, state them: \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_  
If yes, state them. \_\_\_\_\_

**IMMUNIZATIONS: (The following immunizations are required for preschool entrance.)**

DPT 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ (after age 4) OPV/IPV 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ MMR 1. \_\_\_\_\_ 2. \_\_\_\_\_ (after age 4) Hepatitis B 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
VARICELLA (chickenpox) 1. \_\_\_\_\_ 2. \_\_\_\_\_ or date of varicella disease \_\_\_\_\_

\_\_\_\_\_ is under my care. I find him/her in good physical condition. This child is able to enter into routine school activities.

Comments/Restrictions, If Any: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Doctor Date