MEDICAL FORM

All sections must be completed and returned with your child's application.

Child's Name: _____

Mother's Name: _____ Father's Name: _____

Street Address: _____ P.O. Box:_____

Sex: M F Date of Birth:_____

TO BE COMPLETED BY CHILD'S PHYSICIAN:

AGE	VACCINES ADMINISTERED
2 MONTHS	D.P.T. Hib and Oral Poli + Hep B
4 MONTHS	D.T.T., Hib and Oral Polio + Hep B
6 MONTHS	D.P.T., Hib and Oral Poli + Hep B
12 MONTHS	1 st (MMR) Measles, Mumps, Rubella
15 MONTHS	D.P.T. and Hib (Booster Doses)
4-5 YEARS	D.T. (Paed.) Oral Polio and 2 nd MMR

PHYSICAL EXAMINATION

Height: _____ Weight: ____ Temp. BP: _____ Nutritional Status: _____ Posture: _____

Scalp/ Hair: _____ Skin: _____ Neck: _____ ENT: _____ Chest: _____

Abdomen: _____ Reflexes: _____ Deformities: _____

Additional comments if any: _____

_____

_____

Physician's Name:_____ Signature:_____

Address: _____Telephone:_____

Date: _____ Doctor's Stamp:

Please return this copy, signed to The Royal Kidz Academy Administration Office prior to or on the first official day of school for your child. Thank You!