



# 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: \_\_\_\_\_

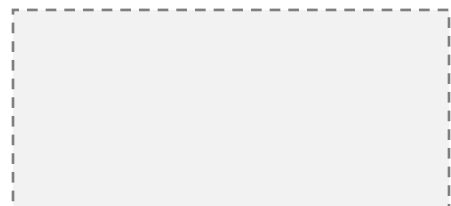
Additional comments if any: \_\_\_\_\_

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

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!