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: ____

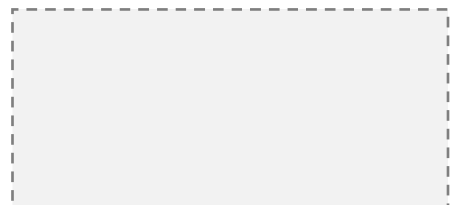
____

____

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!