

Callier Child Development Program Medical Information Form

Child's Name _____ Gender: M F Date of birth _____
 Parent's Name _____
 Address _____ City _____ Zip _____
 Home Phone () - _____ Work Phone () - _____

The following information must be validated by signature of child's pediatrician or health clinic stamp.

Physical examination: (Please comment on any significant findings.)

Skin/Scalp _____ Abdomen _____ Eyes/Vision _____
 Ears _____ Nose _____ Throat _____ Mouth _____
 Teeth _____ Limbs _____ Bones/Joints _____
 Chest _____ Reflexes _____ Heart/Circulation _____

Does this child have any physical disabilities? NO YES (If yes, please explain.)

Does this child have a history of seizures? NO YES (If yes, please give date of last seizure; recommendations/restrictions.)

Is this child physically and mentally able to participate in group activities? YES NO
 (If not, please explain.) _____

Does this child require **SPECIAL CARE in terms of ALLERGIES, SPECIAL DIET, RESTRICTION OF ACTIVITY, or any other condition(s)**? NO YES (If yes, please explain) _____

Hearing screened/ date: _____ P F Vision screened/date: _____ P F

(Or attach copy of child's immunization record maintained by pediatrician's office.)

Immunizations	Date Dose 1	Date Dose 2	Date Dose 3	Date Booster	Date Booster
DTP					
POLIO					
MMR					
PCV					
TB					
Hib					
Hepatitis A					
Hepatitis B					
Influenza					
RotaVirus					
Varicella*					

*(or date child had chickenpox _____)

(Additional information about required immunization at www.dshs.state.tx.us/immunize)

Signature of Pediatrician: _____

Printed name of pediatrician _____ Date: _____