Episcopal Church of the
ASCENSION
DAY SCHOOL
Love. Laugh. Learn.

CHILD'S HEALTH RECORD

CHILD'S NAME_____ DATE OF BIRTH_____

Please attach a print out of the immunization form provided by your physician's office. All forms must include physician's signature.

☐ I have provided the ADS with a copy of my child's immunization records.

The section below is to be completed by your child's pediatrician, including physician's signature:

Is the child free from communicable disease? ☐ Yes ☐ No

Is the child able to participate in group care? ☐ Yes ☐ No

List any of the child's allergies and associated symptoms _____

_____

List any medications and drugs taken regularly by the child _____

_____

Other special physical conditions _____

The above information is correct as of _____/_____/_____ (mo/day/year)

Signature of physician _____

Physician's name _____

Physician's address _____

Physician's phone number _____