MEDICAL TREATMENT FORM

Child's Name ____

Date of last well visit ____

Please list any allergies (including foods, insect bites, medication, etc.):

____

Please list any long-term medications (and their purpose) your child is taking and possible side effects:

____

Please list any medical or behavioral condition(s) of which we should be aware:

____

____

IMMUNIZATION DATES:

DPT	________	________	________	________
Polio	________	________	________	
HepB	________	________	________	
Hib	________	________	________	________
MMR	________	Varicella ________ (or date child had chicken pox)	Prevnar ________	

Physician's Signature ____

Address ____

____

Date ____