Concord University Child Development Center
P.O. Box 1000 D-135, Athens, WV. 24712
304-384-6335

Child's Medical History

Date of Examination _____

Child's Name _____ DOB: _____

Parent's Name _____

Previous or Past Illnesses

___ Measles
___ Mumps
___ Chicken Pox
___ Pneumonia
___ Colds
___ Ear Problems
___ Convulsions
___ Rheumatic fever
___ Scarlet Fever
___ Diabetes

Allergies_____

Foods/Products child should avoid _____

Ongoing Medications _____

Activity/Physical Limitations_____

Past hospitalizations/Serious illness _____

Other illnesses_____

Premature Birth Yes No

Height: _____ Weight:_____ Heart Rate: _____ BP: _____

Immunizations (Fill in the Dates Received)

Hep B 1._____ 2._____ 3. _____

DTaP 1._____ 2._____ 3._____ 4._____

Hib 1. _____ 2._____ 3._____ 4. _____

Polio 1._____ 2._____ 3._____

MMR 1. _____

Varicella 1._____

Prevnar 1. _____ 2._____ 3._____ 4._____

PPD 1._____ Neg/Pos _____ 2._____ Neg/Pos _____

If immunization program is not complete, please indicate a schedule for its completion.

The child is within normal limits of development and is able to participate in a group care program.

_____ _____

Physician's Signature Date