ORCHARD VALLEY
LEARNING - CENTER

HEALTH RECORD / WELLNESS CHECK FORM

Must Be Completed by Child's Physician

Child's Name _____ Birthdate _____

Address _____ Phone # _____

Health Information

Tuberculosis test? Y / N Date _____ Results _____

Chest x-ray? Y / N Date _____ Results _____

Any surgeries? _____

Chronic illness? _____

Does child have allergies? _____

Any developmental delays? _____

Vision normal? Y / N If not, does child need corrective lenses? _____

Hearing difficulties? Y / N Explain: _____

Results of physical exam: _____

Comments/recommendations to school personnel:

_____

Physician's Statement

The child identified above was examined by me on: _____ and was found to be free of any infection or contagious disease and may be admitted to a child care facility where s/he will be placed with other children in group situations.

Doctor's Name: _____

Name of Practice: _____

Doctor's Signature: _____

Attach to this form:

_____ Immunization Card (if new student) _____ Any new immunizations given (if continuing student)