ASHFORD
CHILD ENRICHMENT CENTER
love bless teach

2201 S Dairy Ashford Road, Houston, TX 77077
Phone: 281-497-6901 Fax: 281-497-7574

MEDICAL INFORMATION FORM (2024-25)

Child's Name _____Gender_____ Birth date _____/_____/ _____

Address _____

Physician's Name_____ **Physician's Office Phone** _____

Please answer each question or respond N/A

Allergies _____

Has your child been **diagnosed** with health problems, impairments, or other special needs? _____

_____

Has this child suffered seizures? _____ Explain _____

Has child been hospitalized during the past 12 months? _____ Explain _____

Is child currently taking medication? _____ Explain _____

Is child physically able to participate in a day care program? _____

If not, please list any activities which should be excluded _____

Does child require a special diet? _____

Other health or developmental concerns? _____

Immunizations	Birth	3 Months	5 Months	7 Months	12 Months	18 Months	3 Years	4 Years
DTO/DTap/DT								
HIB								
Polio								
MMR								
Varicella								
Hep B								
Hep A								

PLEASE ATTACH A CURRENT SHOT RECORD.

Please complete the following for children who are 4 or 5 years old.

Hearing Screening: Date: _____/_____/_____ Rescreen Date: _____/_____/_____
_____ Pass _____ Fail _____ Pass _____ Fail

Vision Screening: Date: _____/_____/_____ Rescreen Date: _____/_____/_____
_____ Pass _____ Fail _____ Pass _____ Fail

Speech Screening: (Optional) Date: _____/_____/_____ Name of Test: _____
_____ Pass _____ Fail

_____
Signature of Screener if other than Physician

Physician's Statement: I have examined the above named child **within the past year** and find that he/she is physically able to take part in the day care program.

_____ _____
Physician's Signature Date

Parent Statement: My child has been examined **within the past year** by a health care professional and is able to participate in the day care program.

_____ _____
Parent's Signature Date