ST. CHRISTOPHER MOTHERS' DAY OUT MEDICAL FORM

2024/2025

NAME BIRTH DATE

ADDRESS_____
CITY, STATE,
ZIP_____ PHONE _____

Please fill out this page completely - then take it to your physician for a written statement that the child has been examined within the previous twelve (12) months. (See reverse side.)

TO BE FILLED OUT BY PARENT OR GUARDIAN:

Have or subject to (check if yes)

_____Asthma _____Fainting spells _____Convulsions
_____Diabetes _____ Heart Trouble _____Allergy
_____Other _____None of the above

Please explain_____

Has difficulty with: (check if yes):

_____Eyes, ears, nose, throat
_____Lungs
_____Digestion

Has had:

_____Measles
_____Mumps
_____Chicken Pox
_____Whooping Cough

Please explain. _____

Any conditions now requiring medication? _____

Any restriction of activity for medical or non-medical reasons?
_____

_____

PARENT AUTHORIZATION

This health history is correct so far as I know, and the child herein described has permission to engage in all prescribed activities, except as noted by the physician and me. In the event I cannot be reached in an emergency, I hereby give permission to the MDO staff to obtain medical attention for my child.

Signature_____ Date_____

(SEE REVERSE SIDE)

**** A CURRENT IMMUNIZATION RECORD MUST BE ATTACHED TO THIS FORM**

This child was examined by me on_____ (date) and found to be free of all contagious and transmissible diseases and is physically able, with exceptions noted, to participate in the MDO program.

EXCEPTIONS: _____

_____

_____

Physician's Signature

_____

Physician's Phone Number