ST. CHRISTOPHER MOTHERS' DAY OUT MEDICAL FORM

2025/2026

NAME BIRTH DATE

ADDRESS_____
CITY, STATE,
ZIP_____ PHONE _____

Please fill out this page completely - then take it to your physician for 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 reason?_____
_____

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