TODDLERS INTERNATIONAL NURSERY

## MEDICAL RECORD

Name of Child's Doctor: _____

Address: _____

_____

Serious Accidents / Illness / Operations: _____

_____

| Any Difficulty Regarding: | YES | NO |
|---|---|---|
| Feeding | ☐ | ☐ |
| Ear Infections | ☐ | ☐ |
| Frequent Cold / Cough | ☐ | ☐ |

Hospitilization: _____

Handicaps: (eyes, ears, feet, etc.) _____

Allergies: (Food / Medicine) _____ Blood Group: _____

Communicable Diseases: (Please check the diseases, which your child has had, and give date.)

| | |
|---|---|
| ☐ Chicken Pox | Date: / / |
| ☐ Infectious Hepatitis | Date: / / |
| ☐ Mumps | Date: / / |
| ☐ Whooping Cough | Date: / / |
| ☐ German Measles | Date: / / |
| ☐ Red Measles | Date: / / |
| ☐ Rheumatic Fever | Date: / / |