

# Personal Medical History for Creation Corner

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**Name:**

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**Address:**

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**Date of Birth:**

**Birthplace:**

**Sex:**

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**Phone Numbers**

Home:

Work:

Other:

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**Emergency Contacts:**

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**Health Insurance**

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Carrier Name & Address:

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Group Number:

Subscriber Number:

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**Doctor(s) Name**

**Phone Number**

**Address**

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1.

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2.

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3.

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Date of Last Physical Exam:

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**Current Medications**

**Medication Allergies**

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1.

1.

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2.

2.

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3.

3.

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**Food Allergies**

**Other Allergies**

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1.

1.

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2.

2.

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3.

3.

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**Illnesses & Surgeries:**

Please list and describe any conditions which may affect child's performance in school or treatment in case of an emergency.

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## Immunizations

Type	Date	Date	Date	Date	Date
DTP					
T/D					
Polio					
Polio Booster					
MMR					

I give my consent for my child's  
Physician and Preschool Teacher(s)  
to discuss my child's health concerns.

\_\_\_\_\_  
Signature