DELTA GAMMA CENTER FOR CHILDREN WITH VISUAL IMPAIRMENTS
1750 S. Big Bend Blvd.
Richmond Heights, MO 63117
Phone: (314) 776-1300 Fax: (314) 776-7808

THIS FORM IS TO BE COMPLETED BY THE CHILD'S **PARENT**

Page one is to be completed by the parent/guardian.
Page two is to be completed by a licensed physician.

Child's Name:_____ DOB:_____ Age:_____
Address:_____
Telephone Number:_____
Parent/Guardian:_____

HEALTH HISTORY (Check and give approximate dates)

Ear Infections:_____ Diabetes:_____
Chicken Pox:_____ Measles:_____
Allergies:_____
Cardiac Diseases/Defects:_____
Seizures:_____
Drug Reactions:_____

PREVIOUS SURGERIES/HOSPITALIZATIONS
(Give dates and description)

1)_____
2)_____
3)_____
4)_____

CURRENT MEDICATIONS

Name	Dosage	Time Administered	Reason
Name	Dosage	Time Administered	Reason
Name	Dosage	Time Administered	Reason

Parent Signature:_____Date:_____

PAGE ONE

DELTA GAMMA CENTER FOR CHILDREN WITH VISUAL IMPAIRMENTS
1750 S. Big Bend Blvd.
Richmond Heights, MO 63117
Phone: (314) 776-1300 Fax: (314) 776-7808

Annual Physical Examination Form

THIS FORM IS TO BE COMPLETED BY THE CHILD'S **PHYSICIAN**

Child's Name:_____ DOB: _____
Address:_____
Parent/Guardian: _____Telephone Number: _____

Date of last Examination:_____/_____/_____
Month Day Year

HEALTH HISTORY (If checked, please give approximate dates)

Medical Diagnosis:_____
Visual Diagnosis: _____

Ear Infections:_____ Allergies:_____
Cardiac Diseases/Defects:_____
Seizures:_____
Cardiovascular:_____
Neurological:_____
Extremities/Musculoskeletal:_____
Spine:_____
Other Findings:_____

IMMUNIZATION HISTORY (please complete or attach record)

	DATE	DATE	DATE	BOOSTER	BOOSTER
DPT:					
POLIO:					
MEASLES:					
RUBELLA:					
MUMPS:					
PPD/TB TINE:					
OTHER:					

_____ Administration of PPD/TB Tine is not advised at this time.
_____ This child has no communicable diseases and is medically able to participate in all activities at the Delta Gamma Center for Children with Visual Impairments.
_____ This child has restrictions on physical activity including:
_____

_____ _____ _____
Physician Signature Date Telephone Number

PAGE 2