

**PRESCHOOL EDUCATION CENTER**  
**NEW ORLEANS BAPTIST THEOLOGICAL SEMINARY**  
504-816-8585 Office 504-816-8485 Fax

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**PHYSICIAN'S REPORT**

Child's name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Parent's name \_\_\_\_\_

	DATE OF EACH SHOT				
DTP	_____ 1 <sup>st</sup>	_____ 2 <sup>nd</sup>	_____ 3 <sup>rd</sup>	_____ 4 <sup>th</sup>	_____ 5 <sup>th</sup>
IPV	_____ 1 <sup>st</sup>	_____ 2 <sup>nd</sup>	_____ 3 <sup>rd</sup>	_____ 4 <sup>th</sup>	
HIB	_____ 1 <sup>st</sup>	_____ 2 <sup>nd</sup>	_____ 3 <sup>rd</sup>	_____ 4 <sup>th</sup>	
MMR	_____ 1 <sup>st</sup>	_____ 2 <sup>nd</sup>			
HBV	_____ 1 <sup>st</sup>	_____ 2 <sup>nd</sup>	_____ 3 <sup>rd</sup>		
Chicken Pox	_____ 1 <sup>st</sup>				
PCV7	_____ 1 <sup>st</sup>	_____ 2 <sup>nd</sup>	_____ 3 <sup>rd</sup>	_____ 4 <sup>th</sup>	

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**CHILD'S GENERAL HEALTH** \_\_\_\_\_

Allergies yes \_\_\_ no \_\_\_ If food Doctor please be very specific as to what foods must be avoided.

\_\_\_\_\_ Specify Any  
Handicaps or Limitations. \_\_\_\_\_

Are There Any Prescribed Medications and Drugs of Which the Preschool should Be Aware?  
Yes \_\_\_ No \_\_\_ If Yes, Specify \_\_\_\_\_

This Child is FREE OF ANY CONTAGIOUS OR INFECTIOUS DISEASE.

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_