Gethsemane
EARLY LEARNING CENTER

Child's Name:_____Date of Enrollment:_____

Address:_____Date of Birth:_____Gender: M F

City: _____Zip:_____Home phone #:_____

Parent/Guardian Name: _____

To be completed by a health care provider

Date of last physical exam: _____How long have you been seeing this child: _____

Problems of which we should be aware: _____

Hearing: _____Vision: _____

Allergies: _____

Insect Stings: _____Asthma: _____

Developmental: _____Food: _____

Other (include behavioral Concerns):

_____

_____

Comments/Explanations:

_____

_____

Medication Prescribed / Special Routines / Restrictions for this child:

_____

_____

_____

I have _____ have not _____ reviewed the above information with the parent/guardian.

Physician: _____

Address: _____

Telephone: _____

Signature: _____Date/Completed: _____

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