Simon Says
Early Childhood Center

11015 MUELLER ROAD
ST. LOUIS, MO 63123 (314)842-3435
CHILD ENROLLMENT FORM

I. IDENTIFYING INFORMATION

PATIENT'S NAME | BIRTHDATE

II. CURRENT STATE OF HEALTH

I HAVE EXAMINED THE ABOVE NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH

☐ **ARE** ☐ **ARE NOT** **SATISFACTORY FOR PARTICIPATION IN A CHILD CARE PROGRAM.**

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? ☐ **YES** ☐ **NO**

IF YES, EXPLAIN IN SECTION IV.

III. IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	DOSE NO. 1	DOSE NO. 2	DOSE NO. 3	DOSE NO. 4	DOSE NO. 5	DOSE NO. 6
_____ **DPT/DT/DTAP**						
_____ **Polio**						
_____ **Hib**						
_____ **MMR**						
_____ **Hepatitis B.**						

IV. COMMENTS/RECOMMENDATIONS

(SPECIAL DIENTS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN | DATE | PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME OF CLINIC, GROUP PRACTICE, OTHER | IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME

ADDRESS (STREET, CITY, STATE, ZIP CODE) | TELEPHONE NUMBER ( )