# Bearwood Academy

1490 Seminola Blvd. Casselberry, FL 32707

# MEDICAL PROFILE

## CHILD'S NAME

| First Name | M. I | Last Name | Date of Birth:Day / Month / Year |
|---|---|---|---|
| | | | |

| Name of Child Family Physician | | |
|---|---|---|
| Physician's address: Street No. | City | Postal Code |
| | | |
| Physician's Phone No | | |
| | | |

## ALLERGIES

| | | |
|---|---|---|
| Does your child suffer from any allergies ? | Yes ☐ | No ☐ |
| If yes, Please give details of foods or items suspected of causing the allergy | | |
| Is your child receiving or to be provided any medication for the allergy. | | |

## GENERAL

| | | | |
|---|---|---|---|
| HAS YOUR CHILD EVER HAD HIS/HER EYES TESTED ? | Yes ☐ | No ☐ | Result |
| HAS YOUR CHILD EVER HAD HIS/HER HEARING TESTED ? | Yes ☐ | No ☐ | Result |
| IS YOUR CHILD CURRENTLY RECEIVING ANY MEDICAL TREATMENT ? | Yes ☐ | No ☐ | |
| IF YES STATE DETAILS AND MEDICATION: | | | |
| ANY OTHER MEDICAL CONCERNS OR DETAILS YOU WISH TO PROVIDE | | | |

**SPECIAL REQUIREMENTS :** PLEASE PROVIDE INSTRUCTIONS, IF ANY, ABOUT ANY SPECIAL REQUIREMENTS FOR YOUR CHILD'S DIET, REST OR EXERCISE:

**IMMUNIZATION RECORD :** PLEASE PROVIDE A PHOTOCOPY OF CHILD'S LATEST IMMUNIZATION CARD

**Parent's Signature**_____ **Date**_____