CHILD'S NAME: ________________________________

MEDICAL DOCTOR:

Name : ______________________________________________________________________

Address: ______________________________________________ Phone: ________________

Date Initial Appointment was set: _____________ Date of Initial Appointment: _____________

Date of follow-up appointment (each 12 months): ______________________________________

Copies in file? Yes No

DENTIST:

Name : ______________________________________________________________________

Address: _______________________________________________ Phone: _______________

Date Initial Appointment was set: _____________ Date of Initial Appointment: _____________

Date of follow-up appointments (each 6 months): ______________________________________

Copies in file? Yes No

EYE DOCTOR:

Name: _______________________________________________________________________

Address: ____________________________________________ Phone: __________________

Date of Appointments (each 12 months): _____________________________________________

Copies in file? Yes No

MEDICATIONS:

Prescribed by: _______________________________________________________________

Name of Medication: ____________________ Name of Medication: __________________

Time Taken: __________________________ Time Taken: _________________________

Dosage: ______________________________ Dosage: _____________________________