Sugar Maples Center Medical Form
Art Explorers 2023

CHILD IMMUNIZATION RECORD

THIS FORM IS REQUIRED BY THE NYS DEPARTMENT OF HEALTH

CHILD'S FULL NAME: _____

FAMILY PHYSICIAN: NAME: _____

ADDRESS: _____

PHONE: _____

DISEASE	DATE OF IMMUNIZATION
Tetanus	
Booster	
Diphtheria	
Measles	
Mumps	
Polio	
Rubella	

Allergies to Medication: _____

Allergies to Food: _____

Other Allergies: _____

AUTHORIZATION: In case of any injury or sudden illness, I hereby authorize any hospital or doctor to render emergency aid as might be required at the time for his/her health and safety.

_____ _____

Print: Parent of Guardian Name Signature of Parent or Guardian

_____ _____

Print: Witness Name Signature of Witness

_____

Date