

**CRANFORD PUBLIC SCHOOLS
Cranford, NJ**

MEDICAL ENROLLMENT FORM

Name: _____ Date of Birth : _____

Health Information (to be completed by parents)

Asthma _____ Eczema _____ Meningitis _____ Other _____

Cardiac _____ Hepatitis _____ Pneumonia _____ Lyme _____

Chicken Pox _____ Immune Disorder _____ Rheumatic Fever _____

Bronchitis _____ Tuberculosis _____ Seizure Disorder _____ Other _____

Allergies (describe) _____

Other: (operations, serious injuries, convulsions etc) _____

List any relevant disability _____

Indicate any vision or hearing difficulty _____

List any medications _____

THIS SECTION TO BE COMPLETED BY THE FAMILY PHYSICIAN ONLY

Immunizations:

1. DPT _____
Date Date Date Date Date

2. Polio _____
Date Date Date Date

3. MMR _____
Date Date

OR

Measles Vaccine _____
Date Date

Mumps _____
Date

Rubella _____
Date

