My Child's Vital

Child's Name_____ Sex ❑ Male ❑ Female

Birthdate _____ Blood type _____

Distinguishing marks (moles, freckles, scars) _____

Allergies _____

Medications _____

Prior surgeries _____

_____

Pediatrician/family physician _____

Child's Name_____ Sex ❑ Male ❑ Female

Birthdate _____ Blood type _____

Distinguishing marks (moles, freckles, scars) _____

Allergies _____

Medications _____

Prior surgeries _____

_____

Pediatrician/family physician _____

Information

Child's Name_____ Sex ❑ Male ❑ Female

Birthdate _____ Blood type _____

Distinguishing marks (moles, freckles, scars) _____

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