

My Important Tests

Child's Name: _____

Date of Birth: _____

| Type of Test | Date of Test | Doctor | Telephone | Results | Comments |
|--------------|--------------|--------|-----------|---------|----------|
| Blood | | | | | |
| X-ray | | | | | |
| CT | | | | | |
| MRI | | | | | |
| Other | | | | | |

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