Date ____/____/_____ *Please complete both sides*

Wake Forest Presbyterian Preschool

Children's Medical Report

Name of Child _____ Birthdate ____/____/____

Parents/Guardian _____

Address _____

City, ST Zip _____

Medical History (to be completed by parent/guardian)

1. Is the child allergic to anything?	☐ Yes	☐ No
2. Is the child currently under a doctor's care?	☐ Yes	☐ No
3. Is the child on any continuous medication?	☐ Yes	☐ No
4. Any previous hospitalizations or surgery?	☐ Yes	☐ No
5. Any history of significant previous diseases?	☐ Yes	☐ No
6. Any recurrent illnesses?	☐ Yes	☐ No
7. Does the child have diabetes?	☐ Yes	☐ No
8. Has the child had convulsions?	☐ Yes	☐ No
9. Has the child had heart trouble?	☐ Yes	☐ No
10. Any physical disabilities?	☐ Yes	☐ No
11. Any mental disabilities?	☐ Yes	☐ No

If you answered "yes" to any of the above, please describe: _____

_____

_____

_____

Have speech, hearing, or vision ever been tested? ☐ Yes ☐ No

If you answered "yes", please explain: _____

_____

_____

Signature of parent/guardian _____ Date _____

Date ____/____/_____ *Please complete both sides*

Immunization History (Health official must enter the date immunization was received in the space below OR attach a copy of the immunization record.) G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter the date of each dose (mm/dd/yyyy)

Vaccine	#1	#2	#3	#4	#5
*DTP/DT (circle)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
Other					

*Required by state law

**Required by state law for children born on or after 10/01/1988

***Required by state law for children born on or after 07/01/1994

Physical Examination (This examination must be completed and signed by a licensed physician, his/her authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse.

Height _____% Weight _____ Head _____ Eyes _____

Ears _____ Nose _____ Teeth _____ Throat _____

Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ Date _____ ☐ Normal ☐ Abnormal

Should activities be limited? ☐ Yes ☐ No If "yes", please explain: _____

_____

Signature of authorized examiner/title _____

Date of examination ____/____/____ Phone # _____

Address _____

_____