

New Philadelphia Moravian Church Preschool

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CHILDREN’S MEDICAL FORM

Name of Child _____ Age _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

Home Phone _____ Cell Phone _____

PHYSICAL EXAMINATION: This examination must be completed and signed by a licensed physician or his or her authorized agent.

Date of Examination _____

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____ Neck _____

Heart _____ Chest _____ GU _____ Ext _____ Neurological System _____ Skin _____

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

Any other recommendations: _____

IMMUNIZATION HISTORY: The health official must enter, in the appropriate space, the date each immunization was received.

VACCINE	DATE OF EACH DOSE				
DTP/DT	1 _____	2 _____	3 _____	4 _____	5 _____
Polio	1 _____	2 _____	3 _____	4 _____	
Hib	1 _____	2 _____	3 _____	4 _____	
MMR	1 _____	2 _____			
Varivax	1 _____				

Physicians Signature _____ Date _____

Address _____ Phone _____

(OVER)

This medical report must be on file by the first day of school

CHILDREN'S MEDICAL HISTORY

(To be completed by parents)

Please list previous hospitalizations or surgeries _____

Describe significant previous diseases/recurrent illness _____

Is child currently under a doctor's care? If yes, for what reason? _____

Describe any physical condition requiring special attention by the preschool staff: _____

Does child have any developmental delays? Please describe _____

History of: Diabetes _____ Convulsions _____ Heart Trouble _____

Medication(s) prescribed _____

Possible side effects of medication(s) _____

Allergies _____

Prescribed routine for allergies _____

Parent Signature: _____

Date: _____