This form is only for K3, K4, and K5 students and is to be completed by the physician and parent.

PRE-SCHOOL CHILD'S MEDICAL REPORT

Child's Name_____Date of Birth_____

Parent's/Guardian'sNames_____

Address_____Telephone #_____

Immunization Certificate (Blue Slip) – **Must be current & submitted to the office**

I examined this child on (date) _____. I find him/her to be in good physical condition and free of contagious and infectious diseases.

He/she is capable of participating in preschool activities: Yes_____ No_____
(If no, please list the reasons below.) _____

_____

Any physical or medical conditions the school needs to know about? Yes___ No__
(If yes, please list below.) _____

_____

Immunizations are up-to-date for age of child: Yes_____ No _____

Laboratory and Other Tests: Yes_____ No_____

History of Allergies: _____
_____

_____ _____

Physician's Signature **Date**

NOTE: Parents need to complete the information on reverse side for complete medical history

MEDICAL HISTORY

IT IS MANDATORY that pupils who show symptoms of communicable disease be excluded from classes until readmission is acceptable to School authorities. Your cooperation will be greatly appreciated. Thank you!

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Pupil's Name_____Birth Date_____Sex__

Father's Occupation_____Mother's Occupation_____

PAST DISEASES-(If your child has had any of the following, state age when he/she had them.)

Mumps_____	Diphtheria_____	Polio_____
Measles_____	Scarlet Fever_____	Convulsions_____
Whooping Cough_____	Rheumatic Fever_____	Heart Disease_____
Asthma_____	Chicken Pox_____	Diabetes_____
Hay Fever_____	Pneumonia_____	Discharging Ears_____
	Syphilis_____	Gonorrhea_____

RECENT HEALTH PROBLEMS – (Please check any one of the following noted recently.)

4 or more colds yearly_____	Fainting spells_____	Hearing difficulty_____
Frequent sore throat_____	Abdominal pains_____	Tires easily_____
Poor vision_____	Frequent urination_____	Breath shortness_____
Frequent leg pains_____	Allergy_____	Hernia (rupture)_____
Dizziness_____	Persistent cough_____	Ringworm_____
Frequent sties_____	Speech Difficulty_____	Nose bleeds_____
Dental defects_____	Crippling conditions_____	Growing pains_____

Does your child have a disability due to disease or accident?_____

Has your child had a skin test for tuberculosis? _____Date administered_____

Has he been associated with a tubercular patient? _____ When?_____

PERSONAL RECORD –Please answer all of the following.

Is he/she shy?_____	Overactive?_____	Bite fingernails?_____
Suck thumb?_____	Have excessive fears? ____	Have temper tantrums?_____
Inquisitive?_____	Play well with others?____	Eat breakfast?_____

DATE:_____ SIGNATURE OF PARENT:_____

PHONE:_____ (REV. 01/2016)