Saint Andrews Presbyterian Preschool

Children's Medical Report

Child's Name _____ Birthdate _____

Parent(s) Names _____

Medical History

This section should be completed by parent.

1. Does your child have any allergies? ☐ YES ☐ NO Please describe:

   _____

2. Does your child use rescue medicines for severe allergies? ☐ YES ☐ NO Please describe:

   _____

3. Is your child currently under a doctor's care? ☐ YES ☐ NO Please elaborate:

   _____

4. Does your child take any medication on a regular basis? ☐ YES ☐ NO For what purpose?

   _____

5. Previous hospitalizations or operations? ☐ YES ☐ NO Please elaborate:

   _____

6. Does your child have any physical limitations? ☐ YES ☐ NO Please describe:

   _____

7. Does your child have a history of recurrent illness? Please check any that apply:

   ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Heart Problems ☐ Bleeding

   Other (please explain) _____

Please indicate any conditions that may impair your child's ability to participate in preschool activities or ways that the preschool can enhance your child's school experience:

_____

_____

_____

Parent Signature _____ Date _____

(continued on back)

Immunizations

This section must be completed and signed by a licensed physician, physician's assistant, certified nurse practitioner or public health nurse meeting DEHNR standards for EPSDT program. Please write the date (Month/Day/Year) each immunization was given or attach an official copy of child's immunization history.

VACCINE	#1	#2	#3	#4	#5
DTaP/DT Please circle one					
Polio					
Hib					
Pneumoccal conjugate					
Hepatitis B					
MMR (combined doses)					
Varicella					

Date of child's last physical examination _____

Signature of authorized examiner _____

Printed name _____

Title _____ Phone _____

Office Address _____

_____

Saint Andrews Presbyterian Preschool

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