



NORTH RALEIGH PRESCHOOL MEDICAL FORM

Student Information

Child's Name: _____ DOB: _____
Parent's Name: _____ Phone: _____
Parent's Address: _____

Medical History (May be filled out by parent)

Previous Hospitalization: Yes No If so, details please: _____

Is child allergic to anything: Yes No If so, what? _____

Any previous illnesses or diseases? Yes No If so, what? _____

Any physical handicaps? Yes No If so, please describe: _____

Is child under the care of a Doctor: Yes No If so, for what reason: _____

Any history of retardation: ____ Yes ____ No Any history of diabetes in the family: ____ Yes ____ No
Any history of convulsions: ____ Yes ____ No Any history of heart disease: ____ Yes ____ No

Parent Signature: _____ Date: _____

Physical Examination: (Must be completed and signed by examining physician)

Weight:	Height:	Heart:	Chest:
Throat:	Neck:	GU:	Teeth:
Skin:	Head:	Eyes:	Ears:

Neurological System: _____

Result of Tuberculin test if given:

Type: Results:

Should activities be limited:

Recommendations:

Immunizations: (enter each date immunization received)

HIB	1:	2:	3:	4:	
DBT	1:	2:	3:	4:	5:
POLIO	1:	2:	3:	4:	5:
MEASLES	1:	2:	3:	4:	5:
RUBELLA	1:				
MUMPS	1:				

Comments:

Physician's Name:

Date of Examination:

Office Address:

Phone: