Medical Report of Child in Pre-School

To be completed by Physician, Physician's Assistant or Nurse Practitioner

Name_____ Date of Birth_____
Date of Exam_____

Immunizations

Include all dates:

DPT			
Polio			
HIB			
HepB			
MMR			
Varicella			

Health Specifics

___Yes ___No Are there allergies? (Specify)
___Yes ___No Is medication regularly taken? (Specify drug and condition.)
___Yes ___No Is a special diet required? (Specify diet and condition.)
___Yes ___No Are there any hearing, visual or dental conditions requiring special attention?
___Yes ___No Are there any medical or developmental conditions requiring special attention?

Summary of Physical Exam

_____
_____
_____
_____
_____

On the basis of my findings as indicated above and on my knowledge of the above named child, I find that (s)he is free from contagious and communicable disease. ___Yes ___No

_____ _____
Signature of Examiner Address

_____ _____
Name (Please print) City, State, Zip

_____ _____ _____
Title Phone Date