

CHILDREN'S MEDICAL REPORT

St. Paul's Episcopal Preschool
 520 Summit Street, Winston-Salem, NC 27101 Phone: 336-723-4395

Name of child _____ Birthdate _____

Name of Parent/Guradian _____

Address of Parent/Guardian _____

Physical examination: This examination must be completed and signed by a licensed physician, his authorized agent, a certified nurse practitioner, or a public health nurse. The examination must be within 12 months prior to the first day of school for the current school year.

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

Neck _____ Heart _____ Chest _____ Lung _____ Skin _____ Genital _____

Abdomen _____ Extremities _____ Neurological _____ Emotional _____

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

Does child have any chronic conditions? _____

Any specific recommendations? _____

Should activities be limited? _____ If yes, explain: _____

Signature of authorized examiner: _____ Title: _____

Date of examination: _____

Office Stamp

Immunization History: Enter the date immunization was received in the space below or attach a copy of the immunization record.

Enter date of each dose – month/day/year

VACCINE	#1	#2	#3	#4	#5
DPT					
Hepatitis					
Polio					
Hib					
MMR					
Chicken Pox					

This medical report must be on file at St. Paul's Preschool prior to the child's attendance.

CHILD'S MEDICAL HISTORY – to be completed by parents

1. Currently under doctor's care or on continuous medication? _____ If yes, explain: _____

2. Any hospitalizations, surgeries or broken bones? _____ If yes, what and when? _____

3. Any history of significant previous diseases/recurrent illness? _____ If yes, what and when? _____

4. Any disabilities or developmental delays? _____ If yes, explain: _____

5. Is your child receiving any of the following on a regular basis? If yes, explain.
___ speech therapy ___ occupational therapy ___ physical therapy ___ psychological counseling

6. Other special conditions that may affect your child's interaction in the classroom? _____ If yes, explain:

7. Is child toilet trained? ___ 8. Allergies: _____
9. Please circle all of the following diseases &/or chronic conditions that the child has had:

Chicken Pox
Infectious Hepatitis
Scarlet Fever

Asthma
Diabetes
Epilepsy

Hearing Problems
Vision Problems
Convulsions

Respiratory infections
Urinary tract infections
Ear infections

MEDICAL RELEASE

We/I hereby give authorization and consent for the rendering to our/my child, _____ by a licensed physician or physicians, such medical services and treatment as may become necessary or advisable during the time our/my child is in the care of St. Paul's Episcopal Preschool, regardless of whether such treatment or services become necessary by reason of an emergency, unanticipated conditions, or otherwise. Such consent and authorization shall include also the cooperation and assistance of any qualified medical personnel working under the supervision of licensed physicians.

We/I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on our/my child's condition.

We/I hereby acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered.

We/I hereby give authorization for the use of 911 medical services for immediate treatment and transportation in emergency situations.

In case of emergency, we/I would like for our/my child to be cared for at _____ Hospital.

Mother' Signature: _____ Date: _____

and Father's Signature: _____ Date: _____

Parents are: ___ married ___ separated ___ divorced. If divorced, custody arrangements are: _____

This form must be signed by both parents/guardians. In the case of divorce, the parent with primary custody of the minor child must sign; in joint custody, the signatures of both parents are required.