



CLEMMONS UNITED METHODIST PRESCHOOL

3700 Clemmons Road

P. O. Box 829

Clemmons, NC 27012

Phone: (336) 766-9593

Fax: (336) 766-0652

CHILDREN'S MEDICAL FORM

Name of Child _____ Age _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

Phone _____

PHYSICAL EXAMINATION:

This examination must be completed and signed by a licensed physician or his or her authorized agent who is currently approved by the NC Board of Medical Examiners.

Date of Examination _____

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____

Throat _____ Neck _____ Heart _____ Chest _____ GU _____

Ext _____ Neurological System _____ Skin _____

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

Any other recommendations: _____

IMMUNIZATION HISTORY:

The health official must enter the date immunization was received in the space below.

VACCINE	DATE OF EACH DOSE				
DTP/DT	1 _____	2 _____	3 _____	4 _____	5 _____
Polio	1 _____	2 _____	3 _____	4 _____	
Hib	1 _____	2 _____	3 _____	4 _____	
MMR	1 _____	2 _____			
Varivax	1 _____				

Physician's signature _____ Date _____

Address _____ Phone _____

THIS MEDICAL FORM MUST BE ON FILE BY THE FIRST DAY OF SCHOOL.

CHILD'S MEDICAL HISTORY
(To be completed by parents)

Please list previous hospitalizations or surgeries: _____

Describe significant previous diseases/recurrent illness: _____

Is child currently under a doctor's care? If yes, for what reason? _____

Describe any physical condition requiring special attention by the preschool staff: _____

Does child have any developmental delays? Please describe: _____

History of: Diabetes _____ Convulsions _____ Heart Trouble _____

Medication(s) prescribed: _____

Possible side effects of medication(s): _____

Allergies that staff should be aware of: _____

Prescribed routine for allergies: _____

Parent's Signature _____ Date _____