Part Day Preschool Association
Children's Medical Report

Parent complete:

Name of Child_____Gender___Birth Date_____

Name of Parent or Guardian_____

Address_____

Is child allergic to anything? Yes___ No___ If yes, what?_____ Epi-Pen needed? Yes___No___

What are the allergic reactions?_____

Please list any medical or behavioral conditions about which we should be aware_____

_____

Is child on any continuous medications? Yes___No___ If yes, what?_____

Is child receiving speech, physical, occupational, or other therapy? Yes___No___ If yes, please share objectives of therapy _____

_____

Child's Physician/Practice Name _____ Phone #_____

Signature of Parent or Guardian _____ Date_____

Physician Complete:

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board), a certified nurse practitioner, or a public health nurse.

Are immunizations current? Yes___ No___ If no, please explain_____

_____ **Please attach a copy of immunization record.**

Children in preschool programs have opportunity to participate in both active and quiet, group and individual activities. Should any activities be limited? Yes___ No___ If yes, please explain_____

_____

Developmental Evaluation: Delayed___ Age appropriate___ If delay, note significance and special care needs_____

_____

Any other recommendations_____

_____

Date of last examination_____

Physician/examiner Signature_____ Date_____

Name_____Phone_____

Address_____