

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 _____

Abdomon _____ 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. Is your child currently under a doctor's care or on continuous medication? _____ If yes, please explain:

Please list any medications your child may need at school: _____

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, please explain: _____

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

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

7. Please note if your child has a food allergy. _____ Please list any dietary limitations (gluten, dairy, etc.) that your child has: _____ A food allergy action plan, completed by your child's physician, is required.

8. Please list any serious allergies your child has to any insects, medications, etc. _____

9. Is your child toilet trained? _____ If not, are you working on this or planning to in the near future? _____

10. Please circle all of the following diseases &/or chronic conditions that your child has :

Asthma	Diabetes	Epilepsy/seizures	Hearing problems	Heart condition
Hepatitis	Vision Problems	Blood disorder (Hemophilia, Sickle Cell Anemia, etc.)		

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's signature: _____ Date _____

Father's signature: _____ Date _____

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

This form must be signed by both parents/guardians. [Primary custody -1 signature; joint custody-2 signatures.]