



## SOAPSTONE PRESCHOOL CHILDREN'S MEDICAL REPORT

Name of Child \_\_\_\_\_ Child's Birthdate \_\_\_\_\_  
 Name of Parent or Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address of Parent or Guardian \_\_\_\_\_

**A. Medical History (May be completed by parent or guardian)**

1. Is child allergic to anything? No \_\_\_ Yes \_\_\_ If yes, what? \_\_\_\_\_  
 2. Is child currently under a doctor's care? No \_\_\_ Yes \_\_\_ If yes, for what reason? \_\_\_\_\_  
 3. Is the child on any continuous medication? No \_\_\_ Yes \_\_\_ If yes, what? \_\_\_\_\_  
 4. Any previous hospitalizations or operations? No \_\_\_ Yes \_\_\_ If yes, when and for what? \_\_\_\_\_

5. Any history of significant previous diseases or recurrent illness? No \_\_\_ Yes \_\_\_  
     diabetes? No \_\_\_ Yes \_\_\_  
     convulsions? No \_\_\_ Yes \_\_\_  
     heart trouble? No \_\_\_ Yes \_\_\_  
     asthma? No \_\_\_ Yes \_\_\_

If others, what/when? \_\_\_\_\_

6. Does the child have any physical disabilities? No \_\_\_ Yes \_\_\_ If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 Any mental disabilities? No \_\_\_ Yes \_\_\_ If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**\*\* Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_**

**B. Physical Examination:** This examination must be completed and signed by a licensed physician or other appropriate health care personnel.

Height \_\_\_\_\_ ft. \_\_\_\_\_ in. percentile \_\_\_\_\_ % Weight \_\_\_\_\_ lbs. percentile \_\_\_\_\_ %  
 Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_  
 Heart \_\_\_\_\_ Chest \_\_\_\_\_ Abd/GU \_\_\_\_\_ Ext \_\_\_\_\_ Neurological System \_\_\_\_\_ Skin \_\_\_\_\_

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

Should activities be limited? No \_\_\_ Yes \_\_\_ If yes, explain \_\_\_\_\_  
 Any other recommendations? \_\_\_\_\_

**\*\* Signature of authorized physician/title \_\_\_\_\_ From \_\_\_\_\_ Office Name \_\_\_\_\_**

Date of Examination (between 8/31/23-8/30/24) \_\_\_\_\_ Phone # \_\_\_\_\_

**C. Immunization History:** The health official must provide the date immunization was received. Check if attached

Vaccine	#1	#2	#3	#4	#5
DTP					
Polio					
Hib					
MMR					
Hepatitis B					
Varivax					
Hep A					
Other					