



SOAPSTONE PRESCHOOL CHILDREN'S MEDICAL REPORT

Date of Examination (between 8/31/25-8/30/26) _____

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 ___
seizures/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 developmental delays/intervention services? 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 8/31/25-8/30/26) _____ Phone # _____

C. Immunization Record: Please upload your child's most recent immunization record (must be dated between 8/31/25-8/30/26) from your physician's office to Procure.