Around the Son Preschool
1984 Hendersonville Rd., Asheville, NC 28803
(828)684-2645
Children's Medical Report

Name of Child_____Birthdate _____

Name of Parent or Guardian_____

Address of Parent of Guardian _____

A. Medical History (May be completed by parent)

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___.

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, his/her authorized agent currently approved by the N.C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____inches Weight _____ lbs.

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: _____

_____

Date of Examination_____

Signature of authorized examiner/title_____Phone #_____