

# Hope Lutheran Preschool

## Medical Information

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### History of Medical Information

(May be completed by Parent)

1. Does your child have any allergies? \_\_\_\_\_ If so, please explain \_\_\_\_\_

2. Is your child currently under a doctor's care? \_\_\_\_\_ If so, please explain \_\_\_\_\_

3. Does your child take any medication on a regular basis? \_\_\_\_\_ If so, please explain \_\_\_\_\_

4. Please list any previous hospitalizations or operations: \_\_\_\_\_

5. Does your child have any physical disabilities? \_\_\_\_\_ If so, please explain \_\_\_\_\_

6. Does your child have any mental disabilities? \_\_\_\_\_ If so, please explain \_\_\_\_\_

### Has your child had any of the following: (check all that apply)

- |  |   |                                       |   |                                  |
|--|---|---------------------------------------|---|----------------------------------|
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Mumps         | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Asthma  |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Convulsions/Seizures |                                       |   |                                  |

### Does your child have chronic:

- |                                      |                                |                                    |                                     |
|--------------------------------------|--------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Colds | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Nosebleeds |
|--------------------------------------|--------------------------------|------------------------------------|-------------------------------------|

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

**Please see back of sheet for Physical Exam Information →**

## Physical Examination

**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 from bordering states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.**

Date of last physical examination \_\_\_\_\_ Weight \_\_\_\_\_% Height \_\_\_\_\_%

Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_

Heart \_\_\_\_\_ Chest \_\_\_\_\_ Abdomen \_\_\_\_\_ GU \_\_\_\_\_ Ext \_\_\_\_\_ Neurological System \_\_\_\_\_

Skin \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Results of TB Test, if given: Type \_\_\_\_\_ date \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ followup \_\_\_\_\_

Developmental Evaluation: Delayed \_\_\_\_\_ Age appropriate \_\_\_\_\_

If delayed, note significance and special care needed: \_\_\_\_\_

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

Any other recommendations: \_\_\_\_\_

Immunizations	Date	Date	Date	Date	Date
DTP/DtaP	1	2	3	4	5
IPV/OPV (Polio)	1	2	3	4	
HIB	1	2	3	4	
HEP B	1	2	3		
MMR (Measles, Mumps, Rubella)	1	2			
Varicella (Chicken Pox)	1				
Prevnar	1	2	3	4	
Current Tuberculosis Test					

Would you recommend this child for preschool?  Yes  No

Date of Examination \_\_\_\_\_

Physician's signature \_\_\_\_\_ Phone \_\_\_\_\_