CHILD'S LAST NAME, FIRST NAME:

THE CHILDREN'S CIRCLE PRESCHOOL

2024-2025 MEDICAL REPORT *(to be completed by child's physician)*

Name of Child_____DOB_____School Year_____

Parent or Guardian_____Primary Phone #_____

Address_____

Child's Physician_____Physician's Phone_____

Physician's Address_____

A. Medical History (May be completed by parent)

1. Allergies No____ Yes____ Please list:_____
2. Asthma No____ Yes____ List medications:_____
3. Diabetes No____ Yes____ List medications:_____
4. Seizures No____ Yes____ Disease date:_____
5. Is the child on any continuous medication? No____ Yes____ If yes, what?_____
6. Any previous hospitalizations/surgeries? No____ Yes____ If yes, when and for what?_____
7. Any history of significant previous diseases or recurrent illness? No____ Yes____
   If others, what/when? _____
8. Does the child have any physical disabilities: No____ Yes____ If yes, please describe:_____
9. Is child currently under a doctor's care? No____ Yes____ If yes, for what reason? _____
10. Any developmental 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 _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____

Throat_____ Neck_____ Heart_____ Chest_____ Abd/GU_____

General Appearance: Good_____ Fair_____ Poor_____

Ext_____ Neurological System_____ Skin_____

Tuberculin Test Results, if given: Date_____ Type_____ Normal_____ Abnormal_____

Developmental Evaluation: delayed _____ age appropriate _____

If delay, note significance and special care needed: _____

Should activities be limited? No____ Yes____ If yes, explain: _____

Any other recommendations:_____

Immunization Record: Attach a copy of the immunization record. *G.S. 130A-155(b) requires all childcare facilities to have this information on file.*

Required Immunizations: DTP or DT (Diphtheria, Tetanus, Pertussis), Polio, MMR, Measles [Mumps, Rubella (combined doses)], Hib (Haemophilus influenza type B), Varicella (Chicken Pox), Other

Signature (authorized examiner/title)_____ Date of Examination_____