Trinity Preschool Physical Examination Report

Name _____ Gender M__ F__

Age _____ Birth date _____

Parent/Guardian _____

Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

History of Illness (Please circle those that apply)

Chicken Pox	Strep Throat	Tuberculosis
Measles	Rheumatic Fever	Convulsions
German Measles	Ear Infections	Diabetes
Mumps	Hepatitis	Pneumonia
Scarlet Fever	Poliomyelitis	

Please tell of any other serious illness, allergies, injuries, or surgery _____

_____

_____

Please circle any of the following symptoms that have been noted or are frequent

Cold	Ear infections	Sore throats nose
Coughing	Sties	bleeds
Pains in limbs/joints	Dizziness	Fainting
Shortness of breath	Tires easily	Hernia
Abdominal pain	Urinary problems	Convulsions

Other _____

Does your child have any allergies? Please list and explain. _____

_____

Is your child on medication or under medical care? _____

_____

Has your child had an eye examination? Yes _____ No _____ Date _____

Does your child need glasses? Yes _____ No _____

Does your child have regular check-ups from physician? Yes _____ No _____

Does your child have regular dental care? Yes _____ No _____ Date of last visit _____

TO BE COMPLETED & SIGNED BY YOUR PHYSICIAN

Patient's Name _____ Birth date _____

Current State of Health:
I have examined the above named child and verify that this child's medical history and current state of health _____ are _____ are not satisfactory for participation in a child care program.

Does this child have any specialized care? _____ yes _____ no (If yes, please explain below.)

Comments/Recommendations:
(Special Diets, Allergies, Ear Infections, Convulsions, Diabetes, Emotional Problems)

_____

_____

_____

_____

DOSE	**DATES GIVEN**							
	DTP, DT OR DTaP	DTP/Hib	Hib	OPV or IPV	Hepatitis B	MMR	Td	PCV
DOSE 1								
DOSE 2								
DOSE 3								
DOSE 4						Varicella		
DOSE 5					HBIG	1		
DOSE 6						2		
DATE	**ADVERSE REACTIONS**							

Signature of Physician or registered Nurse under the supervision of a Physician	Date	Physician's or Nurse's Name (please print)
Name of Clinic, Group Practice, other	If Nurse is Supervised by Physician, indicate Physician's name	
Address (Street, City, State, Zip Code)		Telephone