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 _______________________

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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)

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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