Ministry of Education
Department of Education
The Early Childhood Care and Education (Preschool) Unit

CONFIDENTIAL MEDICAL REPORT FOR PRESCHOOLERS

PART I

(To be completed by Parent or Guardian)

1 CHILD'S NAME:

2. CHILD'S DATE OF BIRTH: ____/____/____ **SEX:** M [ ] F [ ]
day month year

3. a. MOTHER'S NAME: _____

b. MOTHER'S PLACE OF BIRTH: _____

4. a. FATHER'S NAME: _____

b. FATHER'S PLACE OF BIRTH: _____

5. NUMBER OF SIBLINGS:

6. FAMILY HEALTH: Good [ ] Illnesses [ ]
If any illnesses state: _____

7. CHILD'S EATING HABIT: Good [ ] Problem Eater [ ]

8. CHILD'S BEHAVIOR: plays well with other children [ ] shy or withdrawn [ ] fights/hits [ ]

9. a. CHILD'S PERSONAL PHYSICIAN:

b. CLINIC ATTENDING:

PART II

(To be completed by Parent or Guardian and Medical Attendant)

10. CHILD'S HEALTH HISTORY, PAST ILLNESS OR SURGICAL PROCEDURES:

11. MEDICAL HISTORY

Allergies: yes [ ] no [ ]

If yes, state _____

Child's General Health Status: Good [ ] Fair [ ] Poor [ ]

	yes	no		yes	no		yes	no
Measles			Rubella			Iron Deficiency		
Seizures			Mumps			Anemia		
Tonsillitis			Chicken Pox			Asthma		
Sickle Cell Disease			Scarlet Fever			Worms		
						Pneumonia		

PART III

(To be completed by physician)

GENERAL APPEARANCE AND NUTRITIONAL STATUS: Good [ ] Fair [ ] Poor [ ]

Height: _____ **Weight:** _____ **Blood Pressure:** _____

Skin:

Mucus Membranes:

Head/Neck/Dentition:

Eyes/Ears/Nose/Throat:

Heart: _____ **Lungs:** _____

Abdomen: _____ **Genitals:** _____

Rectal (if indicated):

FITNESS

Gross assessment of power, tone coordination

Laboratory Test: Hgb [ ] U/A [ ] Stool OVA & Parasite [ ]

Disposition: General Health: Excellent [ ] Good [ ] Poor [ ]

RECOMMENDATIONS:

MEDICATIONS:

RESTRICTIONS:

COMMENTS:

PART IV

Immunization Record

(To be completed by physician or school's administrator)

IMMUNIZATION	1ST	2ND	3RD	BOOSTER
D.P.T.				
POLIO				
M.M.R.				
HIB VACCINE				
TINE/MANTOUX TEST YEARLY				

Physician's Signature: Date: