**WEE Care Preschool**

**118 East South Avenue**

**Wake Forest, N. C. 27587**

**Phone: 919-556-1335**

**Fax: 919-263-3804**

**CHILD’S MEDICAL FORM**

**Age\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street City State ZIP**

**MEDICAL HISTORY**

**1- Previous hospitalization(s): Yes \_\_\_ No \_\_\_ If so, Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2- Is child allergic to anything? Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3- Previous Illnesses? Yes \_\_\_ No \_\_\_ If so, What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4- Any Operations? Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5- Any physical handicaps? Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6- Is child currently under care of a doctor? Yes \_\_\_ No \_\_\_**

**If so, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7- Any history of developmental delays? Yes \_\_\_ No \_\_\_**

**8- Any history of convulsions? Yes \_\_\_ No \_\_\_**

**9- Any history of diabetes in family? Yes \_\_\_ No \_\_\_**

**10-Any history of heart trouble? Yes \_\_\_ No \_\_\_**

**Note: The Physical Examination form on the reverse side is to be**

**completed by the child’s Physician and returned before school starts.**

**(OVER)**

**PHYSICAL EXAMINATION page 2**

**(To be filled out by the Family Doctor or Pediatrician)**

**Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Results of Examination:**

**NORMAL ABNORMAL (DESCRIBE ABNORMAL)**

**1- \_\_\_EYES \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2- \_\_\_E-N-T \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3- \_\_\_HEART \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4- \_\_\_LUNGS \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5- \_\_\_ABDOMEN \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6- \_\_\_GENITALIA \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7- \_\_\_MUSCULOSKELETAL \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8- \_\_\_NEUROLOGICAL \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**9- \_\_\_SKIN \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Weight \_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure \_\_\_\_\_\_\_\_\_\_\_**

**I recommend this child for Weekday Early Education Preschool: Yes \_\_\_ No \_\_\_**

**REQUIRED IMMUNIZATIONS**

**DtaP 1 \_\_\_\_\_\_\_\_ 2 \_\_\_\_\_\_\_\_ 3 \_\_\_\_\_\_\_\_ 4 \_\_\_\_\_\_\_\_ 5 \_\_\_\_\_\_\_\_**

**Hib 1 \_\_\_\_\_\_\_\_ 2 \_\_\_\_\_\_\_\_ 3 \_\_\_\_\_\_\_\_ 4 \_\_\_\_\_\_\_\_**

**Polio 1 \_\_\_\_\_\_\_\_ 2 \_\_\_\_\_\_\_\_ 3 \_\_\_\_\_\_\_\_ 4 \_\_\_\_\_\_\_\_**

**Hep B 1 \_\_\_\_\_\_\_\_ 2 \_\_\_\_\_\_\_\_ 3 \_\_\_\_\_\_\_\_**

**MMR 1 \_\_\_\_\_\_\_\_ 2 \_\_\_\_\_\_\_\_**

**Varicella 1 \_\_\_\_\_\_\_\_ 2 \_\_\_\_\_\_\_\_**

**PneumoConjugat 1 \_\_\_\_\_\_\_\_ 2 \_\_\_\_\_\_\_\_ 3 \_\_\_\_\_\_\_\_ 4 \_\_\_\_\_\_\_\_**

**Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Latest Exam date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax: 919-263-3804**