

CHILD'S MEDICAL HEALTH REPORT PRESCHOOL (K-4 Only)

Child's Name _____ Date of Birth _____

Parent (s) or Legal Guardian (s) Name _____

Address _____ City _____

It is mandatory that pupils who show symptoms of communicable diseases be excluded from classes until re-admission is acceptable to school authorities. Your cooperation is greatly appreciated.

Recent Health Problems (Please check all that are applicable)

4 or more colds yearly _____	Fainting spells _____	Hearing difficulties _____
Frequent sore throats _____	Abdominal pain _____	Tires easily _____
Poor vision _____	Frequent urination _____	Breath shortness _____
Frequent leg pain _____	Allergies _____	Hernia (Rupture) _____
Dizziness _____	Persistent cough _____	Ringworm _____
Frequent sties _____	Speech difficulties _____	Nose Bleeding _____
Dental defects _____	Crippling conditions _____	Growing pains _____

Does your child have a disability due to disease or accident? _____

Has your child had a skin test for tuberculosis? _____

Is he/she shy? _____	Overactive? _____	Bites fingernails? _____
Sucks thumb? _____	Has excessive fears? _____	Have temper tantrums? _____
Inquisitive? _____	Plays well with others? _____	Eats breakfast? _____

I examined this child on _____. I find him/her to be in good physical condition, free from contagious diseases, and capable of participating in preschool activities, except as noted below.

Date: _____

Physician's Signature