

Perry-Hocking ESC - Early Childhood Program Medical Form

Child's Name _____ Sex _____ Birthdate _____
 Address _____ Phone _____
 Parent's Name _____
 Physician's Name: (please print) _____ Preschool Site: _____

Immunizations

(Please list dates administered and note type, if necessary)

DTP/DTaP	_____	_____	_____	_____	_____
OPV	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Hep B	_____	_____	_____	_____	_____
Hib	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

REQUIRED (by Law) Screenings and Information for Preschool Enrollment

() Height _____ () Weight _____ () Blood Pressure _____
 () Hbg or Hct _____ () Date _____ () Lead results (1 time required) _____ Date _____
 () Diagnosed Allergies (food or drug) or restrictions _____

Comments: _____

Other Recommended Screenings, Tests or Concerns

Urinalysis _____ Date _____ TB Test _____ Date _____
 Sickle Cell (results) _____ Vision _____ Hearing _____ Speech _____
 Concerns _____

Examination Results

	Normal for Age	Abnormal	Not Evaluated	Please explain any abnormalities:
General Appearance				
Behavior				
Growth/Nutrition				
Bones, Joints, Muscles				
Head and Teeth				
Nose, Mouth, Pharynx				
Heart				
Lungs				
Abdomen				
Skin				
Genitalia				
Eyes				
Ears				

Other Information _____

Date _____ (Required) Physician's Signature _____
 Address _____ Phone _____
 Healthf 3/00

Please (✓) check required items in shaded area

