Preschool Physician Report

MCS 233 - Rev 07/13

Child's Name _____ Date of Birth _____ Date of Exam _____

Height _____ Weight _____

Physical Examination

Essentially Normal _____ Abnormalities as follows: _____

Please specify allergy (if applicable) Food _____ Medication _____ Other _____

Physician ordered treatment includes (circle) Epinephrine Autoinjector Antihistamine Multi Dose Inhaler

Is the child able to participate fully in:

Classroom and academic activities? Y N

Physical Education classes? Y N

Competition athletics? Y N

Contact and collision sports? Y N

Limitations include:

_____

_____

_____

IMMUNIZATION INFORMATION

DPT					
MMR					
HEP B					
POLIO					
VARICELLA					
Varicella Date of Disease					
HIB					
TB Test/Result					

If this child has any physical, developmental or behavioral problems, how should the school plan to assist with special programs, placement or attention? _____

_____

_____

Physician's Assessment Summary

Problems:

Recommendations:

Assessment/Screening	**Completed?** (circle response)		**Date of Completion**	**Reason not completed (religious conviction, insurance coverage, physician determination)**
Vision	Yes	No		
Hearing	Yes	No		
Dental	Yes	No		
Lead	Yes	No		
Hemoglobin/HCT	Yes	No		

Physician Signature _____ **Date** _____