

# HINSHAW PRESCHOOL MEDICAL FORM

## School Year \_\_\_\_\_

Name of Student \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name of Parent/Guardian \_\_\_\_\_  
Address of Parent/Guardian \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

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### THIS SECTION IS TO BE COMPLETED AND SIGNED BY THE PHYSICIAN

#### PHYSICAL EXAMINATION

Weight \_\_\_\_\_ Height \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_  
Throat \_\_\_\_\_ Neck \_\_\_\_\_ GU \_\_\_\_\_ Ext \_\_\_\_\_  
Abdomen \_\_\_\_\_ Neurological system \_\_\_\_\_ Teeth \_\_\_\_\_  
Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ -Skin \_\_\_\_\_  
Tuberculosis test results \_\_\_\_\_  
Should there be physical activity restrictions? \_\_\_\_\_  
If so, what restrictions? \_\_\_\_\_

#### IMMUNIZATION HISTORY - PLEASE ENTER DATES OF IMMUNIZATIONS

Rubella \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_  
Polio (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_  
DPT (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_

(State law G.S. 130-87 requires 3 DTP's and 3 doses of oral polio vaccine by age 1 and measles vaccine before age 2.)  
By signing, I as physician have actually immunized this child or I have received actual documentation from another physician that the child has been immunized.

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

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#### MEDICAL HISTORY (TO BE COMPLETED BY PARENT/GUARDIAN)

Please check box if your child has had these diseases - Chicken pox  Scarlet Fever   
Measles  Whooping Cough   
Mumps  Others

Is there a history of heart problems? \_\_\_\_\_ Diabetes? \_\_\_\_\_  
Convulsions? \_\_\_\_\_ Mental retardation? \_\_\_\_\_

Are there any physical handicaps? \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

Does your child have any allergies? (food, seasonal, others) \_\_\_\_\_  
If yes, please explain \_\_\_\_\_

Can we help with the allergy treatment? \_\_\_\_\_

Is child presently under the care of a physician for something other than normal visits? \_\_\_\_\_  
If so, what treatment or care is being pursued? \_\_\_\_\_

Are there any previous hospitalizations for this child? \_\_\_\_\_ If so, why? \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_