Medical Report Form Grey Stone Preschool and Kindergarten

(Parents/Guardians - Please fill out Section A and have your child's doctor fill out Section B and attach and updated copy of your child's immunization records.)

Child's Name:			Date of Birth:		
Name (of Parent/Guardian:				
Addres	ss of Parent/Guardian:				
City: _		State:		_ Zip:	
	n A – Medical History (may				
1.	Is child allergic to anything	g (circle one)? Yes No	o If yes, what?		
2.	Is child currently under a	doctor's care (circle one)?	Yes No If yes,	for what reason?	
3.	Is child on any continuous medication (circle one)? Yes No If yes, what?				
4.	Any previous hospitalization	ons or operations (circle o	ne)? Yes No If y	res, when and for what?	
5.	Any history of significant previous diseases or recurrent illness (circle one)? Yes No Convulsions (circle one)? Yes No Heart Trouble (circle one)? Yes No If others, what/when?				
6.	6. Does child have any physical disabilities (circle one)? Yes No If yes, please describe:				
7.	Does child have any menta	lease describe:			
	Parent/Guardian S	Signature:			
authori		by the North Carolina Boar	d of Medical Examiners	y a licensed physician, his (or a comparable board from andards for EPSDT program.	
\mathbf{Head}_{-}	Eyes	Ears	Nose	Teeth	
				GU	
Extren	n	_ Neurological System		Skin	
Result	of Tuberculin Test (if given	ı) : Type:	Date:		
Normal	l Abnormal _				
Should					
Any ot					
	ure of authorized examiner/ f examination:		Dhone#•		
Jak U	ı vauiiiiauvii		i ποπ ι π•		