Little Lambs Preschool of Our Savior
1400 Route 52
Fishkill, NY 12524
(845) 897-4423

MEDICAL REPORT

CHILD'S NAME_____
BIRTH DATE_____SEX_____PHONE NUMBER_____
HOME ADDRESS_____

IMMUNIZATION AND SKIN TESTING

	Date	Date	Date	Date	Date	Date	Date
DTP							
DATP							
OPV/IPV							
HbPV							
MMR							
Tuberculin Result?_____							
DT							
Hepetitis B Vaccine							
Varicella							
PCV-7							
Pediarix							
Lead Blood test Result?_____							

1. Are there any allergy problems? If yes, please specify.

2. Are there any allergies to drugs? If yes, please specify.

3. Is medication taken regularly? Specify drug and condition.

4. Are there any conditions requiring special attention by the preschool provider?

5. Is a special diet required?

CONTINUED ON BACK...

Hearing Tested Date_____ Date_____

Vision Tested Date_____ Date_____

Past Medical History

Please circle any that your child has had:

Chicken Pox Epilepsy or seizures Tonsillitis Diabetes

Scarlet Fever Heart Disease Urinary Tract Infections

Serious Injury_____

Operations_____

Mental Growth and Development-- Normal_____ Abnormal_____
If abnormal, please describe:

Physical growth and Development-- Normal_____ Abnormal_____
If abnormal, please describe:

List any specific recommendations/ concerns about child's health:

Does your child have any physical or emotional conditions which would restrict him/her at school?
If yes, please describe:

Physician's signature_____ Date_____

Physician's Name _____ Phone #_____

Address_____