

Clifton Park Center Baptist Preschool Medical Report

To Be Completed By Physician, Physician's Assistant or Nurse Practitioner

| | | |
|------|---------------|--------------|
| Name | Date of Birth | Date of Exam |
|------|---------------|--------------|

Immunizations

If one or more of the required medical immunizations is deemed detrimental to this child's health, attach certificate specifying which immunization(s) and complete and sign medical exemption statement on bottom of form.

| | | | | | |
|--------------------|-----------------|-----------------|-----------------|-----------------|---------|
| DTP/DTaP | 1 st | 2 nd | 3 rd | Booster | Booster |
| Polio | 1 st | 2 nd | 3 rd | Booster | Booster |
| HIB | 1 st | 2 nd | 3 rd | 4 th | |
| Hepatitis B | 1 st | 2 nd | 3 rd | | |
| MMR | 1 st | 2 nd | | | |

| | |
|------|--|
| Type | |
| Type | |
| Type | |
| Type | |
| Type | |

Tests

| | |
|--|---|
| <p style="text-align: center;"> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Tine <input type="checkbox"/> Mantoux </p> <p>_____</p> <p style="text-align: center;">Date</p> <p>If <u>positive</u>, attach physician's statement documenting treatment and follow-up.</p> | <p>Lead Screening</p> <p>_____</p> <p style="text-align: center;">Date</p> <p>Attach statement of lead screening</p> |
|--|---|

| Health Specifics | Comments: |
|---|-----------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are there allergies?(Specify) | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Is medication regularly taken? (Specify drug and condition) | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Is a special diet required? (Specify diet and condition) | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any hearing, visual or dental conditions requiring special attention? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any medical or developmental conditions Requiring special attention? | |

Summary of Physical Exam (including special recommendations to Preschool)

On the basis of my findings as indicated above and on my knowledge of the above name child, I find that (s)he is free from contagious and communicable disease
 Yes, No and is able to participate in Preschool Yes, No.

| | |
|-----------------------|------------------|
| Signature of Examiner | Address |
| Name (Please Print) | City, State, Zip |
| Title | Phone & Date |