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	1st	2nd	3rd	Booster	Booster
Polio	1st	2nd	3rd	Booster	Booster
HIB	1st	2nd	3rd	4th	
Hepatitis B	1st	2nd	3rd		
MMR	1st	2nd			

Type	
Type	
Type	
Type	
Type	

Varicella *(Chicken Pox Vaccine)*:

_____

Tests

_____
Date

Results		Specify	
☐ Positive	☐ Negative	☐ Tine	☐ Mantoux

If positive, attach physician's statement documenting treatment and follow-up.

Lead Screening

_____
Date

Attach statement of lead screening

Health Specifics	Comments:
☐ Yes ☐ No Are there allergies?(Specify)	
☐ Yes ☐ No Is medication regularly taken? (Specify drug and condition)	
☐ Yes ☐ No Is a special diet required? (Specify diet and condition)	
☐ Yes ☐ No Are there any hearing, visual or dental conditions requiring special attention?	
☐ Yes ☐ 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

_____
Name (Please Print)

_____
Title

_____
Address

_____
City, State, Zip

_____
Phone & Date