



Blair Road UMC Preschool and After School

Children's Medical Report 2012-2013

Program Name: Blair Road UMC Preschool/After School Fax: 704-545-0256

Parent complete:

Name of Child _____ Gender ___ Birth Date _____

Name of Parent or Guardian _____

Address _____

Is child allergic to anything? Yes ___ No ___ If yes, what? _____ Epi-Pen needed? Yes ___ No ___

What are the allergic reactions? _____

Please list any medical or behavioral conditions about which we should be aware _____

Is child on any continuous medications? Yes ___ No ___ If yes, what? _____

Is child receiving speech, physical, occupational, or other therapy? Yes ___ No ___ If yes, please share objectives of therapy _____

Child's Physician/Practice Name _____ Phone # _____

Signature of Parent or Guardian _____ Date _____

Physician Complete:

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board), a certified nurse practitioner, or a public health nurse.

Are immunizations current? Yes ___ No ___ (All students MUST be immunized. There are NO religious or other exceptions.)

If no, please explain _____

Please attach a copy of immunization record.

Children in preschool programs have opportunity to participate in both active and quiet, group and individual activities.

Should any activities be limited? Yes ___ No ___ If yes, please explain _____

Developmental Evaluation: Delayed ___ Age appropriate ___ If delay, note significance and special care needs _____

Any other recommendations _____

Date of last examination _____

Physician/examiner Signature _____ Date _____

Name _____ Phone _____

Address _____