Plymouth Nursery School
Medical Report
To be completed by a Health Care Professional

Child's Name _____ Birth Date_____
Last First
Parent's Name (or Guardian) _____

Has the child had any of the following illnesses?

	Yes	No		Yes	No
Allergy to:			Rheumatic Fever		
Chicken Pox			Tuberculosis		
Diabetes			Whooping Cough		
Epilepsy/seizures			Other?		

Physical Examination
X = normal limits. Please describe if not normal or referral was made.

_____ Appearance _____ Oral/teeth _____ Skin/lymph nodes
_____ Stomach/abdomen _____ Heart _____ Nose/throat
_____ Ears/hearing _____ Lungs _____ Neurological

Height_____ **Weight**_____ **Vision:** Right eye _____ Left eye_____

Blood Lead Level_____ **Date of test**_____
Note- Lead screening is recommended at 12 and 24 months. If the child has had a lead test prior to this exam, please note the date and result. Otherwise, a test should be performed.

Does the child have any chronic diseases? _____

Is the child on medications?_____

Developmental Screening- X=normal limits, otherwise describe

Personal/social _____ Speech/language_____
Fine motor_____ Gross motor_____

Physician's comments: _____

_____

Health Care Provider Assessment Statement:
___ This child may participate in a developmentally appropriate preschool program with **no** restrictions.
___ This child may participate in a developmentally appropriate preschool program **with these restrictions:**
_____

_____ _____
Physician's signature Date of examination