Orange UMC Preschool Children’s Health Report

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Name of Child Birthdate Name of Parent or Guardian Address of Parent or Guardian

# Medical History (Completed by Parent)

* 1. Is child allergic to anything? If yes, what?
	2. Is child currently under a doctor’s care? If yes, for what reason?
	3. Is child on any continuous medication? If yes, what?
	4. Any previous hospitalizations or operations If yes, when and for what?
	5. Any history of significant previous diseases or recurrent illness? Such as diabetes, convulsions, heart trouble, asthma. Please explain:
	6. Does the child have any physical disabilities? Explain
	7. Any mental disabilities? Explain

# Signature of Parent or Guardian date

1. **Physical 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 from bordering states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.

Height % Weight %

Head Eyes Ears Nose Teeth Throat Neck Heart Chest Neurological System Skin Vision Hearing

Developmental Evaluation: Delayed Age appropriate

If delay, note significance and special therapy or care needed:

Should activities be limited? if yes, explain

Other Recommendations:

# Date of Examination

**Signature of authorized examiner/title:**

 **Phone#**

**Attach a copy of Immunization Record**