PLYMOUTH MEETING FRIENDS SCHOOL

Pre-Kindergarten Health Form

Medical History by Parent & Examination by Family Physician

HEALTH INFORMATION—Parents, fill out this side, turn in COPY to office, while awaiting physician completion of other side

Child's full name _____ Birthdate _____

Family physician name _____ Physician phone number _____

Does your child have any chronic/recurring/special health concerns or conditions? Please explain any "yes" answers:

Visual, speech or hearing problems	☐ Yes	☐ No
Physical illness, injury, or impairment	☐ Yes	☐ No
Diabetic, seizure disorder	☐ Yes	☐ No
Asthma/reactive airway disease	☐ Yes	☐ No
Emotional or behavioral problems	☐ Yes	☐ No
Stomach Aches	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Bladder/Bowel Accidents	☐ Yes	☐ No
Ear Tubes	☐ Yes	☐ No

Does your child require long- term medication? ☐ Yes ☐ No Please specify:

Are there any restrictions on play or physical activities? ☐ Yes ☐ No Please describe:

Are there any specific activities to be encouraged?
Restricted?

Describe your child's operations, hospitalizations, or serious injuries (reasons and dates):

Describe any other important health-related information about your child:

Allergies

Medicine_____ Food _____
Insect bites/Bee sting_____ Other_____

Parent signature _____ Date _____

PRINT Parent name _____ **(continued)**

Main Office *Sandbox* *Teacher* *Date*

PHYSICIAN REPORT -This side to be filled out by licensed physician

IMMUNIZATIONS	Date	Date	Date	Date
Diphtheria & Tetanus				
Polio (circle) OPV IPV				
Hepatitis				
Measles, Mumps, Rubella				
Mumps				
Rubella				
Varicella			Proof of having chicken pox	
(if applicable) Tuberculin test				

PHYSICAL EXAMINATION	Normal	Abnormal	Not Examined	Comments
Height (inches)				
Weight (pounds) BMI				
Pulse ( )				
Blood pressure /				
Hair/Scalp				
Skin				
Eyes/vision				
Ears/hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart- Murmur etc.				
Lung- Adventitious Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Presence of Scoliosis)				

SIGNIFICANT MEDICAL CONDITIONS

	Yes	No	If "yes", explain
Allergies	☐	☐	_____
Asthma/Reactive Airway Disease	☐	☐	_____
Cardiac	☐	☐	_____
Diabetes Mellitus	☐	☐	_____
Gastrointestinal Disorder	☐	☐	_____
Hearing Disorder	☐	☐	_____
Hypertension	☐	☐	_____
Neuromuscular Disorder	☐	☐	_____
Orthopedic Condition	☐	☐	_____
Respiratory Illness	☐	☐	_____
Seizure Disorder	☐	☐	_____
Skin disorder	☐	☐	_____
Vision disorder	☐	☐	_____
Other (specify)	☐	☐	_____

General Appraisal _____

PRINT Physician Name _____ _____

Physician signature

Address _____

_____

Phone _____ Date