

# First Baptist Weekday Preschool

## HEALTH FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Boy  Girl

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Immunizations (Month/day/year)

DTP: \_\_\_\_\_  
DTaP: \_\_\_\_\_  
DT: \_\_\_\_\_  
HIB: \_\_\_\_\_  
IPV: \_\_\_\_\_  
OPV: \_\_\_\_\_  
MMR: \_\_\_\_\_  
Varicella: \_\_\_\_\_  
Hepatitis B: \_\_\_\_\_

### Physician's Examination:

Date of Exam: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Neuro System: \_\_\_\_\_

Cardio: Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Murmur: \_\_\_\_\_

Respiratory: Lungs: \_\_\_\_\_ Asthma: \_\_\_\_\_ Inhaler user: \_\_\_\_\_

GI: \_\_\_\_\_ Special Diet: \_\_\_\_\_ Food Allergies: \_\_\_\_\_

GU: \_\_\_\_\_

Orthopedic: \_\_\_\_\_ Recent Fractures/Sprain: \_\_\_\_\_

Eyes: Vision L eye: \_\_\_\_\_ Vision R eye: \_\_\_\_\_ Both: \_\_\_\_\_ Glasses: \_\_\_\_\_

Ears: Audio \_\_\_\_\_ Tympanogram \_\_\_\_\_ Hearing Aid(s) \_\_\_\_\_

Mouth: \_\_\_\_\_ Nose: \_\_\_\_\_

Throat: \_\_\_\_\_

Recent Surgeries: \_\_\_\_\_

History of Illness: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Any restrictions in activities? \_\_\_\_\_

Is this student taking any medications? \_\_\_\_\_

Diagnosis for taking medication? \_\_\_\_\_

**\*\*\*All medicine must be administered by a parent/guardian**

Physician's Name: (PRINT): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_