



**Good Shepherd Preschool**  
13110 Moss Road  
Charlotte, NC 28273

## Children's Medical Report

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Medical History (to be completed by parents)

1. Previous hospitalization? ..... Yes  No

2. Is this child allergic to anything? ..... Yes  No

Explain: \_\_\_\_\_

3. Any physical handicaps?..... Yes  No

Explain: \_\_\_\_\_

4. Is this child under care of a physician for an ongoing illness/condition?..... Yes  No

If so, for what reason? \_\_\_\_\_

5. Any history of convulsions/seizures? ..... Yes  No

6. Does child have a history of diabetes? ..... Yes  No

7. Does child have a history of asthma? ..... Yes  No

8. Any history of heart troubles? ..... Yes  No

9. Has your child been evaluated for any type of learning delays?..... Yes  No

If so, what were the results? \_\_\_\_\_

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**The other side needs to be completed and signed by children's physician --**



## Physical Examination

(Take this form to your child's doctor's office and ask them to complete it according to the most recent well visit.)

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

Chest: \_\_\_\_\_ Throat: \_\_\_\_\_ Neck: \_\_\_\_\_ Abdomen: \_\_\_\_\_

GU: \_\_\_\_\_ Ext. \_\_\_\_\_ Neurological System: \_\_\_\_\_ Teeth: \_\_\_\_\_

Skin: \_\_\_\_\_ Head: \_\_\_\_\_ Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_

Results of Tuberculin Test, if given: \_\_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Should activities be limited?    Yes             No

This is to certify that I have examined \_\_\_\_\_ and find that he/she is in good physical condition.  
Child's Name

\_\_\_\_\_  
Date of Examination

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

**\*\*\*Attach a copy of immunization record:**