Head Start Preparatory School Medical Form

Medical Examination Report – to be filled out by a physician.

Students Name:______________________ **Known Allergies** ______________________

Age:__________ **Height**__________ **Weight:**__________ **lbs**

BP: _____/_____ **Vision: R**________ **L**__________ **Eyes tested with glasses Yes [ ] No [ ]**

Mark 'X' beside one statement below that describes the heath of the student:

The student has no known medical problems. [ ]

The student has a medical condition which is being investigated [ ]

The student has a medical problem which has been diagnosed and treated [ ]

Mark 'X' beside the medical/ sensory developmental conditions affecting the student from the list below

Kidney Problems [ ]

Diabetes [ ]

Vision Impairment [ ]

Autism [ ]

Hearing Impairment [ ]

Other [ ]

Asthma [ ]

Headaches/Migraines [ ]

Learning Disorder [ ]

Allergies [ ]

Developmental Delay [ ]

Seizures [ ]

Sickle cell [ ]

Heart Problems [ ]

Cancer [ ]

Attention Deficit Disorder [ ]

Please list any other medical condition not indicated or give more information on any selected from the above .

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Has your child ever been admitted to Hospital or had surgery. Yes [ ] No[ ]

If Yes please explain ____

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Date of surgery ______________________

Immunization Record (Official use only to be filled out by the school)

Vaccine	1st Dose	2nd Dose	3rd Dose	Booster
BCG				
DPT				
MMR				
Hib				
Hep B				
Varicella				
(Covid)				
Other ( )				

________________________________(students name) was seen and examined by

________________________________ on __________ day of ___________________ 20___, and is found to be physically healthy and immunized according to the requirements of the Ministry of Health and is free from all communicable diseases. He/she is therefore fit to be registered for admission to school.

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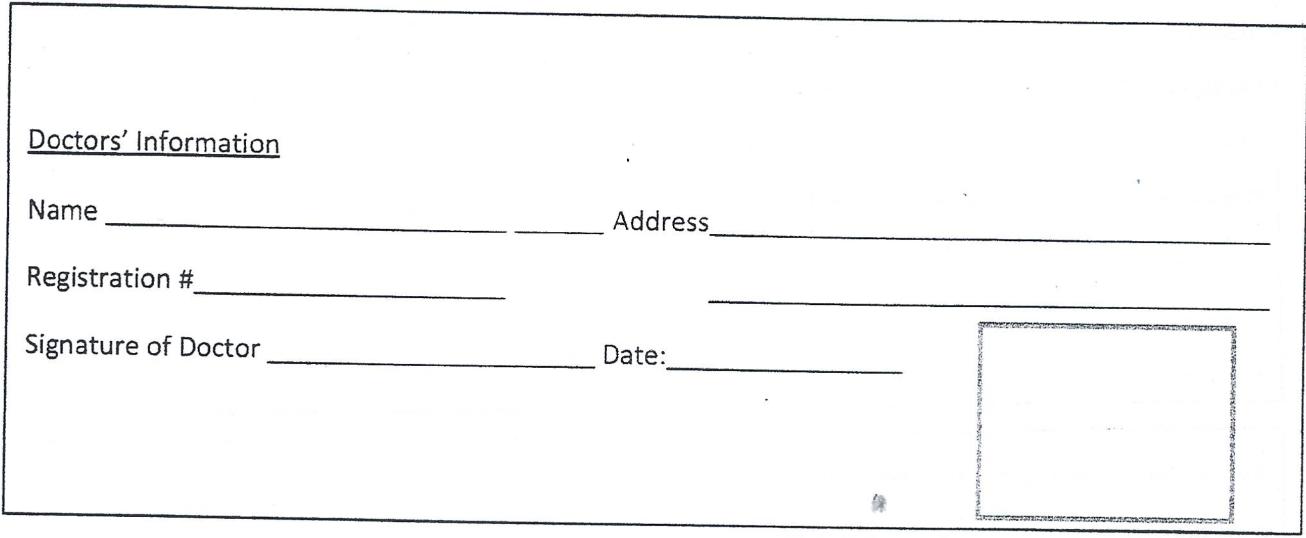
Doctors' signature.



Doctors' Information

Name ____________________________ ______ Address_______________________________________

Registration #______________________ _______________________________________

Signature of Doctor _______________________ Date:________________