ST. VINCENT DE PAUL PRESCHOOL
6828 Old Reid Road
Charlotte, NC 28210
704-644-4656

CHILDREN'S MEDICAL REPORT

PLEASE PRINT

Name of Child: _____ Age: _____ Date of Birth: _____

Names of Parents: _____

Address: _____
Street City State Zip Code

Medical information must be completed and signed by child's physician.

Weight _____ Height _____ Heart _____ Chest _____

Throat _____ Neck _____ Abdomen _____ Teeth _____

Skin _____ Head _____ Eyes _____ Ears _____

Allergies: _____

Results of Tuberculin Test, if given: _____
(type) (results)

Please state condition now and describe any irregularities in the development of:

Speech: _____

Hearing: _____

Sight: _____

Muscle Control: _____

Personality: _____

Should activities be limited? Yes _____ No _____

Recommendations: _____

_____

IMMUNIZATION HISTORY: *Please attach a copy of the child's current immunization record.*

This is to certify that I find _____ is in good physical condition.
Child's Name

_____ _____ _____
Date Physician's signature Physician's phone