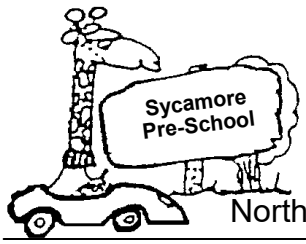

Sycamore Pre-School Medical Form

306 East Second St.
North Manchester, Indiana 46962

Office Phone: 260-982-7537
Office Fax: 260-982-7538

*This medical form is to be completed by your children's physician and returned before your child may begin school. (Please Print)

Child's Name: _____
(First) (Middle) (Last)

Birth Date: ____/____/_____ **Height**: _____ **Weight**: _____

Growth and Development: Normal _____ or Other _____

Vision: With Glasses: _____/_____ Without Glasses: _____/_____

Hearing: Normal _____ Hearing loss noted _____ (details) _____

Physical Examination ("x" if normal / describe if abnormal)

General / Nutrition: _____

Heart: _____ Lungs: _____ Nose/Throat: _____

Teeth: _____ Skin: _____ Speech: _____

Orthopedic: _____ Neurologic: _____

Previous Hospital Admissions: _____

Operations: _____ Serious illness/injuries: _____

Allergies: _____

Physical or emotional handicaps: _____

Any condition which would limit participation in the Pre-School's gross motor activities? _____

If yes to the above, please specify: _____

Additional remarks that may be of value to Sycamore Pre-School: _____

_____

Immunizations (approximate dates—month and year)

Immunizations are incomplete because of: Medical Reason _____ Religious Exemption _____ Allergies_____

DPT	(1) ___/_____	(2) ___/_____	(3) ___/_____	(4)___/_____
IPV or OPV	(1) ___/_____	(2) ___/_____	(3) ___/_____	(4)___/_____
HIB	(1) ___/_____	(2) ___/_____	(3) ___/_____	(4)___/_____
Hepatitis B	(1) ___/_____	(2) ___/_____	(3) ___/_____	(4)___/_____
MMR	(1) ___/_____	(2) ___/_____	(3) ___/_____	(4)___/_____

Varicella (optional at this age) ___/_____

Name of Physician (please print): _____

Signature of Physician: _____ Date: _____

Office Address: _____ Phone: _____