Medical Form

Gingerbread LittleVersity
Fax 919 557-5005

Name of Child ______________________ **Age**_______ **Birth date**____________
Name of Parent ______________________
Address of Parent ____

MEDICAL HISTORY
Previous hospitalization? No ___ Yes ___ If so what? ______________________
Is child allergic to anything? No ___ Yes ___ If so what? ______________________
Any previous diseases or illnesses? No ___ Yes ___ If so what? ______________________
Any operations? No ___ Yes ___ If so what? ______________________
Any physical handicaps? No ___ Yes ___ If so what? ______________________
Is child under care of a doctor? No ___ Yes ___ If so what? ______________________
Any history of mental retardation? No ___ Yes ___ ______________________
Any history of convulsions? No ___ Yes ___ ______________________
Any history of diabetes in family? No ___ Yes ___ ______________________
Any history of heart trouble? No ___ Yes ___ ______________________
Any history of asthma? No ___ Yes ___
____

____
Parent Signature Date

PHYSICAL EXAMINATION

Weight ______ Height ______ Heart ______ Chest ______ Throat ______ Neck ______
Abdomen ______ Gu ______ Ext. ______ Neurological System ______ Teeth ______
Ears ______ Skin ______ Head ______ Eyes ______ Ears ______

Results of Tuberculin Test, if given ______________________________
Type Results

Should activities be limited? No ___ Yes ___ If so
describe______________________________
Recommendations
____
____

Immunization History (enter date of each immunization received or attach copy)

DTP 1._________ 2. _________ 3. _________ 4. _________
Polio 1. _________ 2. _________ 3. _________ 4. _________ 5. _________
MMR 1. _________ 2. _________
Varcella 1. ________ HepB 1.________
Hib 1. _________ 2. _________ 3. _________ 4. _________

____
Physician Signature Date

____
____
____
____
Physician Address & Phone Number

1521 North Main Street Fuquay-Varina, NC 27526
919 552-GRAD (4723) • www.gingerbreadlittleversity.com