

Miss Barbara's Preschool

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MEDICAL REPORT

Name _____ Date of Exam _____ DOB _____

The above named child was examined and found to be in good general health.

Immunizations	Date	Date	Date	Date	Date
DTP					
Polio					
MMR					
HIB					
Hepatitis B					
Varicella					
Other:					
Allergies:					
Please list any disabilities or special recommendations concerning child's health:					

Is medication taken regularly _____ If yes, specify drug and condition.

Hearing & Speech tested: Date _____ Result _____

Vision tested: Date _____ Result _____

Physicians Signature _____ Date _____

Please copy & attach original immunization record to this form.