Child's Medical Report

Please fax or mail to:

(828) 696-4110
900 Blythe Street
Hendersonville, NC 28791
www.preschool@trinitypresnc.org

Child's Name: _____ Age:_____ DOB:_____

Parent/Legal Guardian Name:_____

Physical Examination: This exam must be completed and signed by a licensed physician, a certified nurse practitioner, or a public health nurse.

Height: _____	Weight:_____	Heart:_____	Chest:_____
Teeth: _____	Neck:_____	Throat:_____	Nose:_____
Eyes:_____	Ears:_____	Abdomen:_____	GU:_____
Ext: _____	Neuro:_____	Skin:_____	Head:_____

Should activities be limited? _____

Recommendations:_____

Signature of authorized examiner/title: _____

Date of exam:_____ Telephone #:_____

Please attach a copy of your child's current immunization records.