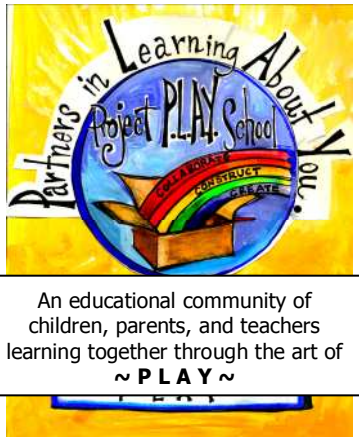


An educational community of children, parents, and teachers learning together through the art of
~ P L A Y ~

Project P.L.A.Y. School

Partners in Learning About You
Co founders Karen Chayot & Kathy Goldenberg
215.740.5751 215.479.6235
www.projectplayschool.com

Health Inventory To be completed by parents

Child's Name _____ Birth date _____ Sex _____

Complete Address_____

_____

Phone _____

Parent's Name_____

Work Phone _____CELL_____

MEDICAL HISTORY - Please describe any accidents, operations or hospitalizations:

_____

_____

_____

_____

COMMUNICABLE DISEASES • Please check those which your child has contracted:

_____Chicken Pox _____Measles _____Mumps

Others _____

_____Whooping Cough _____Rubella (German Measles)

CHRONIC CONDITIONS • Please check those which your child suffers from:

_____Allergy (Food) _____Diabetes _____ Sickle Cell Diseases

_____Allergy (Drug) _____Epilepsy

Others _____

Others con't._____

_____

___

_____Rashes _____Heart Disease _____Asthma _____Rheumatic Fever

_____Convulsions _____Breathing Difficulties

Is your child taking any medication regularly? _____ If so, which one(s)

_____

COMMENTS_____

_____

PLEASE INDICATE ANY CONCERNS OR DIFFICULTIES

_____Frequent colds _____Vision difficulties _____Easily angered

_____Frequent sore throat _____Hearing difficulties _____Worries a lot

_____Frequent ear infection _____Speech difficulties _____Tantrums

_____Running ears/earaches _____Frequent urination _____Many fears

_____Nosebleeds _____Behavioral concerns _____Shyness

_____Toothaches _____Sleeping problems _____Excitable

_____Pain in legs/joints _____Eating problems _____Bed wetting

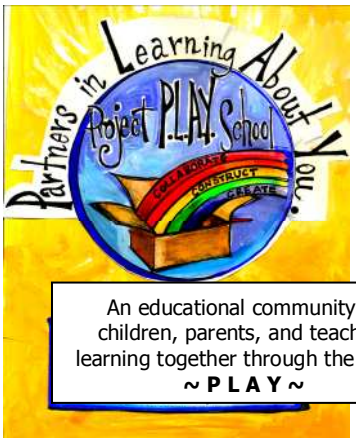
COMMENTS_____

_____

Has your child attended preschool school or day care previously? No_____Yes _____

If yes, please describe the type of program _____

How did your child respond to the program?



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PHYSICIAN'S REPORT

Child's Name _____ Birthdate _____ Sex _____

Significant family history

_____

_____

_____

Overall physical and social development

_____

_____

_____

EXAMINATION

General Appearance:

Skin Ht._____ Wt._____ EENT: Vision: R._____L. _____

Chest:_____Abdomen:_____ Genitalia:_____ Hearing: R._____L._____

Extremities:_____Neurological:_____

Other (include laboratory findings):_____

_____

Teeth:_____

TREATMENT OR MEDICATION NOW BEING GIVEN

_____

_____

SHOULD THIS CHILD BE RESTRICTED FROM ANY ONGOING PRESCHOOL ACTIVITIES?

_____

_____

Physician's Name (please print)

_____Date_____

Physician's Signature_____

Address _____

Phone_____

IMMUNIZATIONS:

_____No TB SKIN TEST needed Check here if child is **NOT** at risk for TB and does not need this test

	#1	**#2**	**#3**	**#4**	**#5**
POLIO					
DPT					
MEASLES, MUMPS, RUBELLA					
HIB MENINGITIS (Haemophilus B)					
HEPATITIS B					
VARICELLA (Chickenpox)					

TB SKIN TEST Date Given Date Read Result