KNIGHTDALE UMC Preschool

Shining the Light of Christ to our Children, Church, & Community

Medical Report

Name of Child_____

Age of Child _____ Birth date _____

Name of Parent or Guardian _____

Address of Parent or Guardian_____

(Street) (City) (State/Zip)

Medical History (to be completed by parent)

1. Previous hospitalization: Yes____ No ____ If so, Why? _____
2. Is the child allergic to anything: Yes___ No___If so, What? _____
3. Any previous disease or illness: Yes___ No___ If so, What? _____
4. Any operations: Yes___ No ___If so, What? _____
5. Any physical handicaps: Yes___ No ___If so, please describe _____
6. Is the child under the care of a doctor, other than for routine care? Yes___No ____
   If so, for what reason:_____
7. Any history of developmental delay: Yes____ No ____ Explain _____
8. Any history of convulsions/seizures: Yes____ No ____ Explain _____
9. Any history of heart problems: Yes____ No ____ Explain _____
10. Any history of diabetes in the family: Yes____ No ____
11. Is your child taking any medications, if so please explain:_____

Signature of parent or guardian_____ Date _____

********Please attach and return a copy of your child's current **immunization record** with this report.**