

*\*Form due within 30 days  
of enrollment @ GCUMC  
Preschool*



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*Guilford College United Methodist Preschool  
1205 Fleming Road, Greensboro, NC 27410  
Office (336) 294-6730 Director (336) 209-3647 Fax (336) 299-8241*

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Names of Parent/Guardian \_\_\_\_\_  
Address of Parent/Guardian \_\_\_\_\_

**A) TO BE COMPLETED BY PARENT/GUARDIAN: MEDICAL HISTORY**



Is child allergic to anything? No \_\_\_\_ Yes \_\_\_\_ if yes, what? \_\_\_\_\_

Is child currently under a doctor's care? No \_\_\_\_ Yes \_\_\_\_ If yes, for what reason? \_\_\_\_\_

Is your child on any type of continuous medications? No \_\_\_\_ Yes \_\_\_\_ If yes, when and what for? \_\_\_\_\_

Has your child had any type of previous operations and/or previous hospitalizations? No \_\_\_\_ Yes \_\_\_\_ If yes,  
Please explain: \_\_\_\_\_

Any significant previous diseases of recurrent illness? No \_\_\_\_ Yes \_\_\_\_ If yes, please explain: \_\_\_\_\_

Heart trouble? No \_\_\_\_ Yes \_\_\_\_

Does your child have any physical disabilities No \_\_\_\_ Yes \_\_\_\_ If yes, please describe: \_\_\_\_\_

Does your child have any mental disabilities? No \_\_\_\_ Yes \_\_\_\_ If yes, please describe: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_

**B) TO BE COMPLETED/SIGNED BY LICENSED PHYSICIAN AND/OR AUTHORIZED AGENT  
CURRENTLY APPROVED BY THE NC BOARD OF MEDICAL EXAMINERS  
C) (OR COMPARABLE BOARD FROM BORDERING STATES).**



**PLEASE ATTACH A COPY OF THE CHILD CURRENT IMMUNIZATION RECORD WITH MEDICAL REPORT**

Head: \_\_\_\_\_ Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Nose: \_\_\_\_\_ Teeth: \_\_\_\_\_  
Throat: \_\_\_\_\_ Neck: \_\_\_\_\_ Heart: \_\_\_\_\_ Chest: \_\_\_\_\_ GU: \_\_\_\_\_  
Ext: \_\_\_\_\_ Neurological System: \_\_\_\_\_ Skin: \_\_\_\_\_

Results of Tuberculin Test, if given: Type: \_\_\_\_\_ Date: \_\_\_\_\_ Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_

Are there any physical disabilities that prohibit this child from participating in a preschool program? \_\_\_\_\_

Should any activities be limited? \_\_\_\_\_

Any other recommendations? \_\_\_\_\_

Signature of Examiner/Title: \_\_\_\_\_ Date of Examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address of Office Where Exam was Performed:  
(Office Stamp Acceptable)