Form due within 30 days of enrollment @ GCUMC Preschool

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 (OR COMPARABLE BOARD FROM BORDERING STATES).

PLEASE ATTTACH A COPY OF THE CHILD CURRENT IMMUNIZATION RECORD

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)