UNIVERSAL PRE-KINDERGARTEN (UPK) CHILD MEDICAL STATEMENT

Child's Name: ____

Address: ____ City: _________________ Zip code: __________

Sex: _____________ Date of Birth: ___________

Insurance Carrier: _____________________________________ UPK Site: ____________________________________

Immunizations	Date(s) Dates are required for all immunizations	
DTaP/DPT	1.	2.
	3.	4.
	5.	
Polio	1.	2.
	3.	4.
Varicella	1.	2.
	3.	
Hepatitis B	1.	2.
	3.	
MMR	1.	2.
HIB	1.	2.
	3.	4.
Other	1.	2.
	3.	
Tuberculin Test Date:		
Survey/Questionnaire		
Reactions and/or contradictions		
Allergies		
Medications		
Child is in suitable condition for enrollment: _____Yes _____No		

Tests & Measurements (If not given, state reason)	
Vision Date: Acuity: Strabismus: Comments:	
Hearing Date: dB: Hz: Comments:	
Hemoglobin (Hgb) Date: Gm:	**Hematocrit (Hct)** Date: %:
Lead Date: Pb:	**Sickle Cell** Date: Results:
Blood Pressure /	**Height:** **Weight**

Examinations and/or Inspections	Normal	Abnormal	Referred/Comments
Eyes			
Ears, Nose, Throat			
Teeth			
Thyroid			
Lymphatic System			
Cardiovascular System			
Lungs			
Breasts			
Abdomen			
Genitalia			
Neurological System			
Skin			
Extremities			
Spine			
Speech/Language			

Physician/Examiner's Name ____ Title____________________

Address: ____ Telephone________________

Physician/Examiner's Signature _______________________________________ Date of Exam_____________