The International Preschool of Warsaw
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MEDICAL EXAMINATION FORM

(This form must be completed by a licensed physician before your child can attend school.)

STUDENT'S NAME: ___________________________ DATE OF BIRTH: ______________

TUBERCULIN SKIN TEST or BCG:

Type of Test___________
Date _________________
Reaction ________________

Does medical evidence or history of recent exposure warrant a chest X-Ray? Yes/No If yes, was an X-Ray taken? Yes/No (Please provide date of X-Ray Report) __________

REQUIRED VACCINATONS:

	Date
DPT Series	_____________
MMR Series	_____________
POLIO Series	_____________
Hepatitis B	_____________

Does patient require any medication for chronic illnesses or allergies? ___________

____
_____

If yes, what dose and how often? ____

I have examined this child and find him/her to be free of any communicable disease.

Signature & Stamp (Physician) ___________________________________
Date___________

Phone number _____________________________________