Sprouts
Warren County Technical School
1500 Route 57
Washington, NJ 07882
908-689-0122
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Preschool Application

Child's Name (Last) (First) (Middle)		Date of Birth
Parent/Guardian Name	Home Phone Number	Work/Cell Phone Number
Parent/Guardian Name	Home Phone Number	Work/Cell Phone Number
I give my consent for my child's Health Care Provider and Child Care Provider/School to discuss the information on this form.		
Signature/Date		

PHYSICAL EXAMINATION REPORT

Date of Physical Exam:	Results of examination were normal? _____Yes _____No		
Weight (lbs/kg)	Height (in/cm)	Head Circumference (in/cm)	Blood Pressure

PHYSICAL EXAM	NORMAL	ABNORMAL/COMMENTS
Head/Ears/Nose/Throat		
Teeth		
Cardio Respiratory		
Abdomen/GI		
Genitalia/Breast		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic/Tone		
Developmental (E.G. DDST)		

IMMUNIZATIONS

VACCINE	BIRTH-1 MO	2 MO	4 MO	6 MO	12-15 MO	18 MO	4-6 YEARS
HEP B	x						
HEP B		x		x			
DTP/Td		x	x	x	x		x
POLIO		x	x	x			x
HIB		x	x	x	x		
MMR					x		x
VARICELLA					x		
OTHER							

APPLICATIONS WILL NOT BE ACCEPTED WITHOUT CHILD'S CURRENT IMMUNIZATIONS. DOCUMENTATION OF A CURRENT FLU SHOT MUST ALSO BE PROVIDED.

MEDICAL HISTORY/CONDITIONS

Chronic Medical Conditions/Related Surgeries *List medical conditions/ongoing surgical concerns:	___None ___Special Care Plan Attached	Comments:
Medications/Treatments *List medications/treatments:	___None ___Special Care Plan Attached	Comments:
Special Equipment Needs *List limitations/special considerations:	___None ___Special Care Plan Attached	Comments:
Allergies/Sensitivities *List allergies:	___None ___Special Care Plan Attached	Comments:
Special Diet/Vitamin & Mineral Supplements *List dietary specifications:	___None ___Special Care Plan Attached	Comments:
Behavioral Issues/Mental Health Diagnosis *List behavioral/mental health:	___None ___Special Care Plan Attached	Comments:
Emergency Plans *List emergency plan that may be needed and signs/symptoms to look for:	___None ___Special Care Plan Attached	Comments:

HEALTH CARE PROVIDER

Name of Health Care Provider (Print)
Signature/Date

Health Care Provider Stamp: