One Per Student

CHRIST CHURCH PRESCHOOL & KINDERGARTEN
2019-2020 Medical Form *(TO BE COMPLETED BY CHILD'S PHYSICIAN)*

CHILD'S INFO			
	(First)	*(Middle)*	*(Last)*
	DOB:	☐ Male	☐ Female

MOTHER	**NAME:**	**FATHER**	Name:

TO BE COMPLETED BY PHYSICIAN:

MEDICAL HISTORY	**DATE OF LAST EXAMINATION:**				
	Normal Hearing	☐ Yes	☐ No	Normal Vision	☐ Yes ☐ No
	Physical Restrictions	☐ Yes	☐ No	Physical Disabilities	☐ Yes ☐ No
	Dietary Restrictions	☐ Yes	☐ No	History of Seizures	☐ Yes ☐ No
	Previous hospitalization and/or recurrent illness: ☐ Yes ☐ No				
	If yes, please elaborate:				
	PLEASE LIST ANY ADDITIONAL MEDICAL CONDITIONS OR NEEDS:				

ALLERGIES	**PLEASE LIST ALL ALLERGIES FOR THIS CHILD:**	☐ Not Applicable
	Is an EpiPen required to be on hand for reactions? ☐ Yes ☐ No	
	Allergy/Asthma action plan required? ☐ Yes ☐ No	

MEDICATIONS	Does this child require regular medication? ☐ Yes ☐ No
	If yes, please list medications:
	Do any medications need to be given at school? ☐ Yes ☐ No
	If yes, explain:

IMMUNIZATIONS	**PLEASE ATTATCH A COPY OF THE CHILD'S MOST RECENT IMMUNIZATION RECORD.**

Physician's Signature **Date**

COMPLETED FORM/IMMUNIZATION RECORDS CAN BE FAXED TO (704) 333-4573 BY SEPTEMBER 1, 2019