



CHRIST CHURCH PRESCHOOL & KINDERGARTEN

One Per Student

2018-2019 Medical Form

(TO BE COMPLETED BY CHILD'S PHYSICIAN)

CHILD'S INFO			
	(First)	(Middle)	(Last)
	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female

MOTHER	NAME:	FATHER	Name:
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TO BE COMPLETED BY PHYSICIAN:

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

ALLERGIES	PLEASE LIST ALL ALLERGIES FOR THIS CHILD:					<input type="checkbox"/> Not Applicable
	Is an EpiPen required to be on hand for reactions? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Allergy/Asthma action plan required? <input type="checkbox"/> Yes <input type="checkbox"/> No					

MEDICATIONS	Does this child require regular medication? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	If yes, please list medications:				
	Do any medications need to be given at school? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	If yes, explain:				

IMMUNIZATIONS	PLEASE ATTATCH A COPY OF THE CHILD'S MOST RECENT IMMUNIZATION RECORD.
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Physician's Signature

Date

COMPLETED FORM/IMMUNIZATION RECORDS CAN BE FAXED TO (704) 333-4573 BY SEPTEMBER 1, 2018