One Per Student

CHRIST CHURCH PRESCHOOL & KINDERGARTEN
2024-2025 Medical Form *(TO BE COMPLETED BY CHILD'S PHYSICIAN)*

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

TO BE COMPLETED BY PHYSICIAN:

MEDICAL HISTORY	**DATE OF LAST EXAMINATION:**	
	Normal Hearing ☐ Yes ☐ No	Normal Vision ☐ Yes ☐ No
	Physical Restrictions ☐ Yes ☐ No	Motor Skill Delays/Challenges ☐ Yes ☐ No
	Chronic Medical Conditions ☐ Yes ☐ No	Speech Delays/Challenges ☐ 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 OTHER CONCERNS/COMMENTS:	

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	**IMMUNIZATIONS ARE UP TO DATE:** ☐ Yes ☐ No Why?: _____ **PLEASE ATTACH A COPY OF THE CHILD'S MOST RECENT IMMUNIZATION RECORD.**

Physician's Signature **Date**

COMPLETED FORM/IMMUNIZATION RECORDS CAN BE EMAILED (NOT FAXED) TO LEEMC@CHRISTCHURCHCHARLOTTE.ORG NO LATER THAN SEPTEMBER 1, 2024.