

**CHRIST CHURCH PRESCHOOL & KINDERGARTEN****2025-2026 Medical Form****(TO BE COMPLETED BY CHILD'S PHYSICIAN)**

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

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	Motor Skill Delays/Challenges <input type="checkbox"/> Yes <input type="checkbox"/> No
	Chronic Medical Conditions <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Delays/Challenges <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 OTHER CONCERNS/COMMENTS:	

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	IMMUNIZATIONS ARE UP TO DATE: <input type="checkbox"/> Yes <input type="checkbox"/> 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, 2025.