MEDICAL INFORMATION FORM (PRESCHOOL)

(PLEASE PRINT CLEARLY)

Student's Full Name: ____
(Last) *(First)* *(Middle)*

Date of Birth: ______________________ Gender: ☐ Male ☐ Female Grade: ________

TO BE FILLED OUT BY PHYSICIAN:

Child's Physician: ______________________________ Phone: ____________________

Address: ____
(Address) (City) (State) (Zip Code)

☐ Immunization record attached ☐ Significant Medical/Surgical history attached

Health/Medical History: Please answer the following questions.

Specify Any Disease:
☐ None ☐ Existing Illness ☐ Asthma ☐ Diabetes
☐ Developmental Problems (I.E. Hearing, Speech, etc.) ☐ Other____________________

Allergies:

☐ Life-Threatening: ______________ ☐ Seasonal ______________

☐ Food ________________ ☐ Insect ________________ ☐ Other ________________

☐ Medication: ________________ ________________ ________________

Medications (list all): _____☐None _____☐ Additional medications see attached
(Administration of Medicine or Special Procedure By School for must be submitted. The Forms are available at the Nurses Station).

Specify medical accommodations needed for school: ☐ none

☐ Known or suspected disability: ____

☐Please monitor: ____

☐ Restrictions: ____

☐Please monitor: ____

DOCTOR'S STATEMENT: I have examined the above named child within the past year and find that he/she is free from contagions and physically qualified for all physical education, sports, and playground, work and school activities at Fellowship Christian Academy.

PHYSICIAN SIGNATURE: ____
Signature of Physician *Date*

PRINT NAME:____