Medical Form

Community of Faith Preschool

TO BE COMPLETED BY CHILD'S PHYSICIAN

Child's Name: _____

Child's Date of Birth: _____

Please list, with instructions, any medications taken routinely and any side effects that we should be alerted to: _____

_____

If special care is needed for allergies, diet, activity, or other chronic condition, please explain: _____

_____

Does this child have special needs: _____ Yes _____ No If yes, please explain including the developmental age:

_____

_____

_____

_____ has been examined by me within the last 12 months and is physically and mentally able to participate in school activities.

Date of Examination: _____

By: _____
Physician's Name

_____
Street Address

_____
City, State, Zip

_____
Phone Number

_____ _____

Physician's Signature **Date**