PHYSICIAN SIGNED MEDICAL FORM

Community of Faith Weekday Preschool

MUST BE COMPLETED BY CHILD'S PHYSICIAN ONLY

Child's Full Name: _____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:_____

_____

(Child's Name):_____
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 /Stamp ***Date***