PHYSICIAN'S STATEMENT

First Presbyterian Preschool, PO Box 586, Lexington, NC 27293

Phone: 336-248-2140 ext.205 Fax: 336-248-6626

IMMUNIZATIONS

Parents: Please have your physician fill out the information below, sign, and attach a current certificate of immunization.

The school is responsible for maintaining a file with up-to-date immunization information for each child enrolled at the preschool. If an immunization record is incomplete, the school must notify the parents that the file must be completed or updated. Written verification of proper immunization must be received within 30 days of notice.

Child's Name: _____ Age: _____ Date of Birth: _____

Parent's Name(s): _____

MEDICAL HISTORY

1. Previous Hospitalizations? Yes____ No____ If so, why?_____

_____

2. Serious Illness/Operation? Yes____ No____ If so, why?_____

_____

3. Physical Handicaps/Limitations? Yes____ No____ If yes, describe_____

_____

4. Allergies? Yes____ No____ If so, what?_____

_____

5. Is the child under doctor's care? Yes____ No____ If so, why?_____

_____

6. Any history of seizures? Yes____ No____

7. Any history of heart condition? Yes____ No____

8. Is the child prescribed any "rescue" medications? (EpiPen, Inhaler, etc.)

Yes____ No____ If so, what? _____

Is this child physically and emotionally able to participate in a preschool program?

_____

Date of most recent examination? _____

Physician's Signature _____ Date _____