

STATEMENT TO PHYSICIAN

Name of Child

Date of Birth

has applied to enter Valley Preschool. This school provides the following programs:

Monday & Tuesday AM Class – 2.5 hours per day

Wednesday, Thursday, and Friday AM Class – 3 to 5 hours per day

Monday, Tuesday, Thursday, and Friday PM Class – 2.5 hours per day

The daily activities range from vigorous outdoor play to quiet indoor activities. Please provide a report on the above named child using the attached form.

Name of Parent or Guardian

Phone Number

Address

PHYSICIAN'S REPORT

_____ is under my professional care and to my knowledge is physically and emotionally equipped to participate in the program at Valley Preschool.

Date of last physical examination _____ How long have you been seeing this child? _____

Exceptions, if any, are:

Allergies (Please name all):

Animals:

Foods:

Bee Stings:

Other:

Medication:

Illnesses (Check those the child has had and record approximate date):

Chicken Pox _____

Measles _____

Rheumatic Fever _____

Mumps _____

Rubella _____

Hepatitis A _____

Hepatitis B _____

HIV _____

AIDS _____

Malaria _____

Whooping Cough _____

Other _____

Was is the status of the child's: Vision _____

Hearing _____

Speech _____

Is the child currently on any medication? _____

Is there any condition present that may result in an emergency? _____

Please list any health problems or special concerns of which preschool staff needs to be aware of: _____

Physician's Name _____ Physician's Signature _____

Address _____ Date _____

Phone Number _____