352 S Main Street Crown Point IN 46307 • Telephone 219-661-9044 • Email cpplayandlearn@gmail.com

Medical History and Physical Examination Report

To Be Completed by Parents

M☐ F☐

Child's Name | Birth Date | Gender

Physician's Name | Phone | Address

Has your child had any serious illness, injury, surgery, or hospital stay? ☐Yes ☐No

If yes, please explain:____

Has your child been recommended for and/or received professional assistance for any of the following ☐Health ☐Vision ☐Hearing ☐Speech/Language ☐Development ☐Psychological

To Be Completed by Physician

Child's Height __________ Child's Weight__________ Shot Record Up-To –Date ☐Yes ☐No

Please indicate any health concerns ☐Allergies________________________________

☐Asthma ☐Diabetes ☐Glands ☐Heart ☐ Lungs ☐Nose ☐Throat ☐Eyes/Vision

May this child participate in playground & gym activity? ☐Yes ☐No

Any other recommendations or restrictions?____

I have examined the above-named child and found him/her to be in satisfactory health. In my opinion, s/he is in suitable physical condition to participate in preschool activities.

X

Signature of Physician | Date

Your child will not be able to enter school without a yearly completed physical form.