



352 S Main Street Crown Point IN 46307

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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.