

Physical Exam

Health Care Provider: Please complete this page

Child's Name _____ Date of Birth _____

Date of Last Physical Exam _____ Recent Weight _____

Vision Exam _____ Hearing Exam _____

Exam: Normal Abnormal

If abnormal, please explain

Significant Health Concerns: None Seizures Diabetes Developmental Delay Vision Hearing
Hospitalizations Operations Allergies

Other (please describe) _____

Explain above concerns (if necessary, include instructions for school staff) _____

Current Medications: _____

Do Medications Need to be Kept/Given at School? Yes No
(If yes, a separate medication consent form must be completed)

Dietary Concerns _____

Immunizations up to Date? Yes No (Please attach immunization record)

Any additional information, recommendations, or restrictions? _____

Signature

I attest that this child is healthy to attend Apple Tree Christian Preschool and Kindergarten in routine activities. Any concerns or exceptions are identified on this form.

Name of Health Care Provider _____

Title _____ Date _____

Signature of Health Care Provider _____

Apple Tree Christian Preschool and Kindergarten

545 W 10th Ave, Broomfield, CO 80020 | P 303-466-8365 | F 303-955-1902 | appletreebroomfield.org