Health Care Provider: Please complete this page

Apple Tree Christian Preschool & Kindergarten

Physical Exam

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

Date of Last Physical Exam: _____ **Next Well visit Per AAP guidelines**_____ **or date**_____
Recent Weight: _____

Vision Exam: _____ **Hearing Exam:** _____

Physical 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_____

Apple Tree Christian Preschool and Kindergarten
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