Physician's Report

Date ________________

Child's Name______________________________ Age______ DOB___________

Physician's Name _______________________________ Phone ________________

Physician's Address ____

Describe any past, current or recurrent medical/developmental concerns (i.e. allergies, ear infections, convulsions, ongoing medications):

The parent received a copy of their child's immunization record and as of today the child is up-to-date on his/her immunizations. Yes No

Hearing/Vision test date ***(required by law for children age 4+)*** _____________________

Please attach a copy or fill out Hearing/Vision results below:

Vision	R 20 / _____	L 20 / _____	☐ Pass	☐ Fail
Signature:			***Date:***	
Hearing	1000 Hz	2000 Hz	4000 Hz	☐ Pass ☐ Fail
R				
L				
Signature:			***Date:***	

Note to Physician: This child is being considered for admission to our Preschool which offers a program of daily activities including vigorous outdoor play and participation. If you know of any reason why this child should not participate in this program, please indicate on this form. In addition please indicate any conditions that the preschool staff should be aware of.

I hereby certify that the above named child is in good physical health and of normal physical and emotional maturity for a child of his/her age.

Physicians Signature ________________________________ Date of Last Exam ____________