PHYSICAL FORM – TO BE COMPLETED BY PHYSICIAN

Falcon District #49 Preschool Programs 719-494-8840

CHILD'S NAME: ______________________________ **BIRTH DATE:** ______________

PAST ILLNESSES – check those the child has had and give approximate dates:

Chicken Pox ______________ Rubella ______________ Rubella ______________

Rheumatic Fever ______________ Asthma ______________ Hay Fever ______________

Diabetes ______________ Mumps ______________ Epilepsy ______________

Whooping Cough ______________ Ear Infections ______________ Polio ______________

PLEASE GIVE LOCATION OF ANY PIGMENTED LESIONS, BIRTH MARKS OR OTHER PERMANENT SCARRING:

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SURGERY / ACCIDENTS / ILLNESSES / CHRONIC HEALTH PROBLEMS: ______________________________

____

LIST ANY PHYSICAL CONDITION REQUIRING OUR SPECIAL ATTENTION AND/OR RESTRICTIONS: ______________

____

LIST ANY DIETARY NEEDS / RESTRICTIONS: ______________________________

MEDICATIONS PRESCRIBED: ______________________________

ALLERGIES: ______________ AND PRESCRIBED ROUTINE: ______________

VISION: ______________ HEARING: ______________

CURRENT HEALTH STATUS: (circle one) EXCELLENT GOOD FAIR POOR

PLEASE ATTACH A COPY OF ALL IMMUNIZATIONS AND DATES GIVEN.

EXAMINATION DATE: ______________

PHYSICIAN'S SIGNATURE: ______________________________

DATE

Please Print: ______________________________

Name of Health Care Professional

Address ______________________________

City ______________ Zip ______________

Phone: ______________ Fax: ______________