

Medical Form

Chrysalis Christian Preschool

TO BE COMPLETED BY CHILD'S PHYSICIAN

Child's Name: _____

Child's Date of Birth: _____

Please list, with instructions, any medications taken routinely and any side effects that we should be alerted to: _____

If special care is needed for allergies, diet, activity, or other chronic condition, please explain: _____

Does this child have special needs: ____ yes ____ no If yes, please explain including the developmental age:

_____ has been examined by me within the last 12 months and is physically and mentally able to participate in school activities.

Date of Examination: _____

By: _____

Physician's Name

Street Address

City, State, Zip

Phone number

Physician's Signature

Date