



Heritage Christian Preschool

Child Medical Statement

Revised 5/2023

Child's Name:			
Date of Birth:	Height	Weight	
Parent/Guardian:			
IMMUNIZATIONS		Exempt from Immunization:	
Complete for Age	<input type="checkbox"/> Yes <input type="checkbox"/> No	Religious Conviction	<input type="checkbox"/> Yes <input type="checkbox"/> No
In Process	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Other (list):	
SCREENINGS			
Vision: R	L	Hearing:	
Speech:		Referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lead:		Hemoglobin:	
Follow-up required?			

Immunizations: please attach a copy of child's Immunization Record including dates of administration

Required Physical Assessment: WNL Yes No _____

Limitations or health conditions: _____

ALLERGIES (include food): _____

Medications and/or dietary restrictions: _____

CHILD MEDICAL STATEMENT VERIFICATION

Physician/Clinic/Hospital Name _____

Address _____

Provider Phone _____ City _____ State _____

Zip Code _____

Check Box of examining medical professional:

- Physician
- Physician Assistant
- Advanced Practice registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____

Date of Exam: _____