

Return by June 15th

Lafayette Christian Preschool
115 New Ballwin Road
Ballwin, MO 63021

Please have this form completed by your physician. Return the form by June 30th.

Child's name _____ Phone _____
 First Last

Address _____
 Street City Zip

Child's Physician _____

Address _____ Phone _____

Immunizations and dates:

| | | | |
|----------------------|-------------|--------------------|-------------|
| Diphtheria _____ | <u>Date</u> | Polio _____ | <u>Date</u> |
| Whooping Cough _____ | | Tuberculosis _____ | |
| Tetanus _____ | | Measles _____ | |
| Mumps _____ | | Rubella _____ | |
| HIB _____ | | HB _____ | |

List communicable diseases child has had _____

Any known allergies _____

Is your child receiving any medication? If so, please state the medication and the reason it is given. _____

Any special problems we should be aware of? _____

Should there be any limitations of physical activities? _____

Date

Signature of Physician