

Member  
A.A.C.S  
A.C.E.A

*Cahawba Christian Academy & Daycare*

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CHILD'S MEDICAL REPORT

Daycare/Preschool

\* This form is to be filled out and signed by your child's physician

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent or Guardian Names \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

***IT IS MANDATORY THAT PUPILS WHO SHOW SYMPTOMS OF COMMUNICABLE DISEASES BE EXCLUDED FROM CLASSES UNTIL RE-ADMISSION IS ACCEPTABLE TO SCHOOL AUTHORITIES. YOUR COOPERATION IS GREAT APPRECIATED.***

RECENT HEALTH PROBLEMS (Please check any of the following that have been noted recently)

|                           |                       |                           |
|---------------------------|-----------------------|---------------------------|
| ____ 4 or more colds/year | ____ Fainting spells  | ____ Hearing difficulties |
| ____ Frequent sore throat | ____ Abdominal pain   | ____ Tires easily         |
| ____ Poor vision          | ____ Allergies        | ____ Frequent urination   |
| ____ Dizziness            | ____ Persistent Cough | ____ Breath Shortness     |
| ____ Speech difficulties  | ____ Hernia (rupture) | ____ Frequent Sties       |
| ____ Crippling conditions | ____ Ringworm         | ____ Dental defects       |
| ____ Growing Pains        | ____ Nose Bleeds      |                           |

Does your child have a disability due to disease, disorder, or accident? \_\_\_\_\_

Has your child had a skin test for tuberculosis? \_\_\_\_\_ Date \_\_\_\_\_ Results \_\_\_\_\_

PERSONAL RECORD (Please check any of the following that apply to your child)

Is(does) he/she:

|                  |                           |                            |
|------------------|---------------------------|----------------------------|
| ____ Shy         | ____ Overactive           | ____ Play well with others |
| ____ Suck thumb  | ____ Have excessive fears | ____ Bite fingernails      |
| ____ Inquisitive | ____ Have temper tantrums | ____ Eat breakfast         |

I examined this child on \_\_\_\_\_, 20\_\_\_\_. I find him/her to be in good physical condition, free of contagious and infectious diseases, and capable of participating in Preschool activities, except as noted below: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_