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MEDICAL FORM 2024-2025

This form is due on or before your child's first day of school.

Child's Name (please print clearly):

Please include a copy of the above named child's immunization records.

Immunization Records Attached ____ yes ____ no

PARENTS:

Does your child have or require:

1. Allergies? No ____ Yes ____ (Please list)

2. Medication? No ____ Yes ____ (Please list)

3. Emergency Contacts (people to contact, after parents, in an emergency):

1. Name: _____ Relationship: _____

Phone: _____

2. Name: _____ Relationship: _____

Phone: _____

3. Name: _____ Relationship: _____

Phone: _____

DOCTOR:

Does the above named child have:

4. Special physical or **medical conditions?** No ____ Yes ____ (Please Describe)

5. Current immunizations? Yes ____ No ____ (please attach record)

6. In your opinion, is this child physically and emotionally ready to attend preschool? Yes ____ No ____

(Why?)

Physician's Signature (required): _____ **Date** _____

Physician's Name Printed:
