Dear Parent:

We would appreciate knowing of any mental or physical problems regarding your child that would help us during his/her preschool years. St. Mark's Preschool is particularly interested in any health problems which would require any restrictions on your child's school activities. It is our belief that this program will enable the home and the preschool to work together more effectively. We appreciate your cooperation and help in this important matter.

Please use the space below to make your comments if applicable.

ST. MARK'S preschool

Where lifelong learning begins.

846-8941 • preschool@stmarkscarmel.org
4780 E. 126th St., Carmel, IN 46033

St. Mark's Fax Number 846-8950

NOTE:
This record is kept confidential.
12/10

REPORT OF PHYSICAL EXAMINATION
ST. MARK'S PRESCHOOL

Name of Student _____

Sex _____ Date of Birth _____

Date of Exam: _____

Parent's Names _____

Address _____

_____

Home Phone _____

Dear Parents,
St. Mark's Preschool requires that your child have all immunizations brought up-to-date, before school begins in the fall. This form must be completed and returned before your child's 1st day of school. The immunizations required by State Law must be documented by month, day and year. St. Mark's Preschool requires that your child be excluded from school if these requirements are not met.

MEDICAL HISTORY *(Please give dates)*

Chicken Pox (month/day/year)_____ Scarlet Fever _____
Whooping Cough _____ Rheumatic Fever _____
Pneumonia _____ Kidney Disease _____
Heart Disease _____ Diabetes _____
Tuberculosis _____ Inf. Hepatitis _____
Seizure Disorder _____ Operations _____
Other Illness _____

(Please Check if Applicable)

Frequent Colds _____ Hay Fever _____ Draining Ears _____
Asthma _____Allergies _____ Please list: _____
_____

Immunizations/Tests	Month/Day/Year	Month/Day/Year
DPT {Diphtheria {Pertussis {Tetanus	_____ _____ _____	_____ _____ _____
Polio	_____ _____ _____	_____ _____ _____
MMR **OR**	_____	_____
Measles Mumps Rubella (3day Measles)	_____ _____ _____	_____ _____ _____
Hepatitis B	_____ _____	_____
Varicella (chicken pox)	_____	_____
Hepatitis A	_____	_____
Other		
Other		

Has your child been tested for: ***(Please indicate Yes or No)***

Sickle Cell Anemia _____ Lead Poisoning _____
Hearing Problems _____ Sight Problems _____

Recommendation for correction or follow-up:

_____

_____

_____

Should physical activity be restricted? _____

If yes, specify degree

_____

_____

Physician Signature

_____