Fox Chapel Presbyterian Church Preschool
384 Fox Chapel Road, Pittsburgh, PA 15238 412-963-8243

HEALTH ASSESSMENT FORM

______________________________ ( ) Male ( ) Female
Name

______________________________ Date of Birth: ______________
Address

______________________________ ______________________________
City, State, Zip Telephone

____
Name of Parent(s)/Guardian

Primary Health Care Physician: ______________________________
Name
____
Address
____
Telephone

Dentist/Other Medical Specialists: ______________________________

____

Does your child have any ongoing medical conditions/mental or physical challenges? ________

____

Please list any allergies your child has: ______________________________

____

Please list any medications your child takes and the doses: ______________________________

____

****Please attach a copy of your child's immunization records**

To be completed by your physician:

I certify that ______________________________ has received a complete examination and is physically and emotionally able to attend the early childhood programs.

______________________________ ______________________________
Physician Signature Date