**ST. JOHN’S PRESCHOOL**

**Health Certificate – DUE 1ST DAY OF SCHOOL**

**2018/2019**

***This form is to be completed by your child’s physician***

This is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is under my treatment and that the following medical history is correct.

**LIST ALL TYPES OF IMMUNIZATIONS AND DATES ADMINISTERED, OR ENCLOSE A PHOTOCOPY FROM THE CHILD’S CHART:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type Date Type Date

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Type Date Type Date

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Type Date Type Date

May participate in physical activities at school? □ Yes □ No

Any abnormalities in vision? □ Yes □ No

Any abnormalities in hearing? □ Yes □ No

Any physical condition that may require special □ Yes □ No

emergency treatment at school?

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return to: St. John’s Preschool

1623 Carmel Road

Charlotte, NC 28226