First Methodist Preschool Forney

2024-2025 PHYSICAL EXAM FORM

(to be completed by PHYSICIAN)

Form due at orientation

Name of Patient:	Height:	Weight:

Doctor's statement: I have examined the above named child within the PAST YEAR and find that he/she is physically able to take part in the Preschool program.

Physician's Signature:	Date:
Physician's stamp or printed name:	
Physician's office address:	Phone number:

Does your child have diagnosed food allergies? ☐ Yes ☐ No **Physician** must fill out FARE form and attach.

Vision Exam Results (4 and 5 year olds ONLY)				
Right Eye 20/ Left Eye 20/ Pass ◯ Fail ◯ Signature_____ Date Signed_____				
Hearing Exam Results (4 year olds ONLY)				
Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				Pass ◯ Fail ◯
Left				Pass ◯ Fail ◯
Signature_____ Date Signed_____				

Requirements for Exclusion from Compliance

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

More information needed on back of form.

All students: Please attach a **COMPLETE list of all Immunizations from birth to present or official state affidavit of any exemptions.

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child had had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about {date} and does not need varicella vaccine.

Signature_____ Date _____

Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food Intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations (past 12 mos)
- ☐ Speech Impediment
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment (include instructions below)
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use
- ☐ Other: _____

Emotional problems or other information that you feel would help the teacher understand your child:

Explain any needs selected above:

Signatures

Child's Parent or Legal Guardian_____ Date signed_____

Center Designee_____ Date signed_____