

**Due by the first day of school**

First Faith Preschool & Kindergarten  
777 N. Walnut Creek Dr.  
Mansfield, Texas 76063

## Medical Information Form

**\*\*MUST BE COMPLETED BY THE PHYSICIAN\*\***

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please attach a copy of this child's most current immunization record to this form.**

Developmental Delays\*: **Yes No**  
If yes, explain: \_\_\_\_\_

Allergies\*: **Yes No**  
If yes, explain: \_\_\_\_\_

Does this child have any other medical conditions\* that should be mentioned (such as asthma, hay fever, etc.)? **Yes No**

If yes, explain: \_\_\_\_\_

**(\*\*\*An Allergy Action Plan Signed by Physician is required for all medically diagnosed Allergies as well as Asthma\*\*\* DUE BY THE FIRST DAY OF SCHOOL)**

### Children ages 4 and up only: Physicians Complete Table Below

**For children four years and older** enrolled in a Texas Department of Protective and Regulatory Services licensed care facility, a vision and hearing screening must be on file for each child indicating the child's name, type of screening, date, screener and results. For hearing screenings, the results must be recorded for both ears at less than or equal to 25dB at the following frequencies: 1000, 2000, and 4000 Hertz. For vision screenings, a distance acuity for the right and left eyes must be recorded (e.g., 20/20, 20/30, etc.).

<b>HEARING @ 25dB</b>			
<b>Hz</b>	<b>1000</b>	<b>2000</b>	<b>4000</b>
R			
L			
<b>VISION</b>			
R 20/ _____		L 20 / _____	

**DOCTOR'S STATEMENT:** I have examined this child within the past year and find that he/she is physically able to take part in preschool/kindergarten.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City, Zip: \_\_\_\_\_