Lakeway Church
Christian Preschool
est. 1989

Medical Health Form

(Fill out by Parent)

Child's Name: _____ Date of Birth: _____

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Number: _____ Fax Number: _____

(Fill out by Physician)

Vision & Hearing Test (children 4 & older)

HEARING Test Date: _____

Circle One

Pass Fail Refer

20db HL 2db HL 40db HL

RIGHT EAR				
LEFT EAR				
	500	1000	2000	4000

VISION Test Date: _____

Circle One

Pass Fail Refer

RIGHT EYE: 20/ _____

LEFT EYE: 20/_____

I have examined the above named child within the last year, date of examination: _____

I find that he/she is physically able to take part in daycare, preschool or school programs and activities.

_____ _____

Physician's Signature Date