PHYSICAL EXAM FORM

2026-2027 SCHOOL YEAR

CLEMMONS FIRST BAPTIST PRESCHOOL

This form must be completed by a licensed medical professional and returned to the address below by August 24th:

Clemmons First Baptist Church Preschool
PO Box 279
Clemmons, NC 27012
Fax: 336-766-1794

CHILD INFORMATION

Full Name: (First, Middle, and Last)

Full Address:

Height: **Weight:** **Sex:** M F

Hearing: **Vision:**

Do you consider that this child is in good physical condition to attend school?

Does this child have any physical restrictions?

Does this child have any allergies? Specify:

Does this child require any special medical treatment that we should be aware of?

Recommendations:

IMMUNIZATIONS: All preschool children are required to be up to date on their immunizations. Please attach a copy of the child's completed immunization record.

Physician Name: **Clinic:**

Full Address:

Exam Date: D D M M Y Y

Physician Signature

THANK YOU FOR YOUR INFORMATION