STUDENT PHYSICIAN'S REPORT for NOAH'S PARK WEEKDAY EARLY EDUCATION

This form may be faxed to **205-383-2662** or emailed to **noahspark@nponline.org**.

PART A—PARENT'S CONSENT (TO BE COMPLETED BY THE PARENT)

Name of Child	Date of Birth

The above named child is being considered for readiness to enter: Noah's Park Weekday Early Education Ministry
This child care center/school provides a program which extends from: 7:00am to 4:30pm five days a week
Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named child care center.

Signature of Parent, Guardian, or Child's Authorized Representative	Today's Date

PART B—PHYSICIAN'S REPORT (TO BE COMPLETED BY THE PHYSICIAN)

Problems of which you should be aware:	
Hearing:	Medicine:
Vision:	Allergies:
Developmental:	Insect Stings:
Language/Speech:	Food:
Other:	Asthma:
Behavioral Concerns:	
Results of M-CHAT-R/F Screening:	
Comments/Explanations:	
MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:	

I have__ have not___ reviewed the above information with the parent/guardian.
The child is cleared to attend preschool ___yes ___no

Physician:	Date of physical exam:
Address:	Date this form completed:
Telephone:	Signature:
Check One: o Physician o Physician's Assistant o Nurse Practitioner	
This section for Noah's Park use only. Information has been reviewed by: Noah's Park director _____ Noah's Park school nurse _____	