ST. JOHN'S PRESCHOOL

Health Certificate

DUE ON or BEFORE the 1ST DAY OF SCHOOL

2026/2027

This form is to be completed by your child's physician

This is to certify that _____ is under my treatment and

that the following medical history is correct.

LIST ALL TYPES OF IMMUNIZATIONS AND DATES ADMINISTERED, OR ENCLOSE A PHOTOCOPY FROM THE CHILD'S CHART:

_____	_____	_____	_____
Type	Date	Type	Date
_____	_____	_____	_____
Type	Date	Type	Date
_____	_____	_____	_____
Type	Date	Type	Date
_____	_____	_____	_____
Type	Date	Type	Date

May participate in physical activities at school? ☐ Yes ☐ No

Any abnormalities in vision? ☐ Yes ☐ No

Any abnormalities in hearing? ☐ Yes ☐ No

Any physical condition that may require special emergency treatment at school? ☐ Yes ☐ No

If yes, please explain_____

_____

Signature of physician_____ Date_____

Return to: St. John's Preschool
1623 Carmel Road
Charlotte, NC 28226