

LCOR PRESCHOOL CHILDREN'S MEDICAL REPORT

NAME: _____ AGE: _____ DOB: _____

PHYSICAL EXAMINATION: This examination must be completed and signed by a licensed physician or his/her authorized agent. Return to:
LCOR Preschool 7500 Market St. Wilmington, 28411 OR Email to preschool@mylcor.org or fax to (910) 805-0486

Please list all allergies or conditions we should know about and any specific information pertinent to them.

Should any activities be limited? If yes, please specify.

Any recommendations or concerns we should be aware of?

Signature of physician or authorized agent

Date of examination

Office address

Phone number