Student's Health Record

All students must have a health examination for the 2018–2019 school year. **A physician's signature is required.**

Child's Name _____ **Sex** Male ☐ / Female ☐ **Birthdate** _____

Physician _____ Phone _____

Address _____ City _____ Zip Code _____

Dentist _____ Phone _____

Address _____ City _____ Zip Code _____

Known Allergies _____

_____

Current Medications _____

Any Required Special Diet _____

Any Chronic Health Conditions _____

Please describe other health concerns/problems that we should know about while your child is in our care.

_____

Current Immunization Form must also be completed and on file before the first day of school.

Health Care Provider (Please complete this section.)

Physical Exam: ☐ Normal / ☐ Abnormal

Significant Health Concerns: ☐ Seizures / ☐ Asthma / ☐ Diabetes / ☐ Allergies / ☐ Heart or Respiratory Conditions

☐ Physical Disabilities / ☐ Other: _____

Any other concerns _____

_____

Information and instructions on any health issues _____

_____

Next scheduled exam date _____

Physician's Signature _____ Date _____

Medical Consent

I hereby give my consent to Community Preschool to seek emergency medical attention for my child. I understand that I accept any expenses incurred.

In the event of an emergency, Community Preschool and its representatives will activate the emergency medical system by calling 911, and then make reasonable efforts to contact a parent or guardian at the numbers listed below.

Date _____

Parent's Signature _____

Parent's Home Phone _____

Parent's Cell Phone _____

Parent's Authorization to Release Student for Treatment

Signature _____ Date _____

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** – positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____