Student's Health Record

All students must have a health examination for the 2019–2020 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 _____