FIRST LUTHERAN CHURCH PRE-SCHOOL
HEALTH RECORD

(This report is to be filled out by a licensed physician, physician's assistant or nurse practitioner who has seen the child within the last 12 months)

CHILD'S NAME____

SEX____________________ BIRTHDATE____

ADDRESS____

____

THIS CHILD IS____ IS NOT____ PHYSICALLY OR EMOTIONALLY ABLE TO PARTICIPATE IN THE PRE-SCHOOL NAMED ABOVE. COMMENTS: ____

____

SURGERY/ACCIDENTS/CHRONIC OR HANDICAPPING PROBLEMS: ____________________________

____

DESCRIBE ANY PHYSICAL CONDITION REQUIRING SPECIAL ATTENTION BY STAFF: _____________

____

MEDICATION(S) PRESCRIBED: ____

____

ANY ALLERGIES STAFF SHOULD BE AWARE OF: _____________________________________

____

VISION SCREENING____

HEARING SCREENING____

DATE OF MOST RECENT EXAMINATION OF CHILD: __________________________________

____ DATE____________________

Signature of licensed physician, physician's assistant or nurse practitioner

PLEASE PRINT PHYSICIAN'S NAME AND ADDRESS _________________________________

____

(OVER PLEASE)

MEDICAL EMERGENCY AUTHORIZATION FORM

CHILD'S NAME____ BIRTH DATE _________________

ADDRESS____

CITY____STATE_____________ZIP___________________

MOTHER'S NAME____

HOME PHONE_________________________WORK PHONE___________________________________

FATHER'S NAME____

HOME PHONE_________________________WORK PHONE___________________________________

NAME OF RELATIVE/FRIEND____

HOME PHONE_________________________WORK PHONE_________________________________

CHILD'S PHYSICIAN____

ADDRESS____

PHONE____

CHILD'S DENTIST____

ADDRESS____

PHONE____

SPECIAL INSTRUCTIONS IF CHILD IS INJURED OR ILL: ____

____

DOES YOUR INSURANCE REQUIRE THAT YOUR DOCTOR BE NOTIFIED BEFORE ANY ACTION IS TAKEN? ___________________________

MEDICAL RELEASE: I authorize First Lutheran Church Pre-School to seek emergency medical treatment for my child. I give permission to the emergency physician to secure proper emergency treatment and to order injection, anesthesia, or other emergency treatment if I (we) cannot be contacted. It is understood that a conscientious effort will be made to locate me or my spouse before action is taken. But if it is not possible to locate us, I ACCEPT THE EXPENSE. In the event of life-threatening emergency, I understand that "911" will be called to take my child to my preferred hospital____ if possible, or to the closest available facility.

____

Parent/guardian's signature Date

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR CHILD'S INSURANCE CARD. (OVER PLEASE)