Health and Medical Information and Authorization Form

2019 Operation Name: St. Philip's Episcopal Preschool		Director's Name Beth Sarey	
Child's Name		Date of Birth	Child's Home Telephone No.
Date of Admission August 26, 2019	Hours and days child will be in care 8:30am – 2:30pm	Days attending	
Parent's or Guardian's Name Mother's Telephone No.		Father's Telephone No.	* 3rd Emergency contact No.
*Give the name and address of person to call in case of an emergency if parents / guardian cannot be reached:			Relationship

CHECK ALL THAT APPLY:

1. ☐ **FIELD TRIPS:** I understand that a parent or guardian must attend with my child in order for them to participate in Field Trips:

Parent's Comments:

2. ☐ **WATER ACTIVITIES:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:
☐ sprinkler play ☐ splashing/wading pools ☐ water table play

IMMUNIZATION REQUIREMENTS

IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / dose 4	Date / booster
DTP / DTaP / DT					
POLIO **IPV or OPV**					
MEASLES Rubeola / Serampion					
MUMPS					
RUBELLA					
ROTAVIRUS					
INFLUENZA					
Hib					
Hepatitis A					
Hepatitis B					
PNEUMOCOCCAL **PCV**					
TB TEST (if required)	☐ Positive	☐ Negative	Date:		
Varicella (see below)					

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date)_____ and does not need varicella vaccine.

_____ _____

Parent's signature **Date**

Signature of Health Care Professional _____ **Date** _____

For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/school_info.htm

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

_____

_____

Health and Medical Information and Authorization Form

Please continue to page two

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.
Please check only one option:

1. ☐ **HEALTH-CARE PROFESSIONAL'S STATEMENT**: I have examined the above named child within the past year and find that he / she is physically able to take part in the day care program.

_____ _____
Health Care Professional's Signature **Date**

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ **PARENT'S STATEMENT**: Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

Vision and hearing screenings must be administered yearly to children four years of age and above. They can be conducted in your Doctor's office as part of their yearly Well Check Exam *or* you may have your child tested at the school by a licensed practitioner during a regularly scheduled time. Check with the school calendar to see the scheduled date for that opportunity.

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		**DATE** _____	

HEARING	**1000 Hz**	**2000 Hz**	**4000 Hz**	☐ PASS ☐ FAIL
R				
L				
SIGNATURE _____		**DATE** _____		

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:
In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:
I give consent for the facility to secure any and all necessary emergency medical care for my child.	_____ **Signature - Parent or Legal Guardian**	

I acknowledge that all the above information is accurate and up to date. I also acknowledge that, as this child's Parent/Legal guardian I am responsible for making the School aware of *any changes* of health, medical information and or emergency contact information in a timely fashion.

_____ _____
Signature – Parent or Legal Guardian **Date**

*Before this form can only be accepted by the school the Parent or Legal Guardian must sign in three separate places and a Health Care Provider must sign in at least two separate spaces. The Vision and Hearing Screening may take place after school is in session with a Licensed Practitioner during a scheduled time. The Licensed Practitioner will add their signature after completing the screenings. Please make sure all necessary signatures are present.

**This form is due to the school by August 19, 2019. Any student enrolled prior to this date whose Information Packet is not completed and returned to the school by August 19, 2019 will be placed on "stand-by" status and their placement in a class may be lost.