ST. FRANCIS OF ASSISI PRESCHOOL HEALTH FORM – EMERGENCY RELEASE FORM

****This Section to be fill out by Parent or Guardian****

Child's Name: ______________________________________**Has your child been tested or received medical or professional services for any of the following?** Learning Disability: ____ Yes ____No, Febrile or Seizure Disorder: ____Yes ____ No, Speech Therapy: ____Yes ____ No, Developmental Delay: ____ Yes ____ No, Vision or Hearing Impairment: ____ Yes ____ No What is the primary language spoken in the home?________________ Does your child take any medications regularly? _____Name of meds & dosage______________________________

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Does your child have any food allergies?_____ Please describe:____

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Is there information about your child that you feel may be helpful in the Preschool meeting your child's needs? ___ If yes, please describe:____ ______ ___________

Authorization for Emergency Medical Attention: In the event that I cannot be reached to make arrangements for emergency medical attention, I hereby authorize the Director or person in charge to take my child to Baylor Medical Center (817-481-1588) 1650 College, Grapevine, TX 76051. If emergency medical services are called, the facility of choice will be determined by E.M.S.

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Insurance Carrier Policy Number/Group ID Number **Signature of Parent/Guardian** **Date**

To be completed by a Physician or an official copy may be attached. Physician signature required on all copies

Child's Name: ______________________________ **Age:** ______**Birth Date:** ____/____/_____

Immunizations:	**Date 1st Dose**	**Date 2nd Dose**	**Date 3rd Dose**	**Date 4th Dose**	**Date 5th Dose**
DTaP					
POLIO					
PNEUMOCOCCAL					
HIB					
RV					
HEPATITIS B					
HEPATITIS A					
MMR VACCINE					
CHICKEN POX VACCINE (Varricella)					
TB TEST					

Each child entering the St. Francis of Assisi Preschool is required to present the following statement certifying that the child has been currently examined by a physician, is physically able to participate in the school program, and all immunizations are up to date. Physician's statement: I have examined the above-named child within the past year and find that he/she is physically and mentally able to take part in the Preschool's program.

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Physician's Name (Please print) Address Phone

______________________________ ____________

Physician's Signature (Mandatory) **Date of last checkup**

Preschool Staff Initials: _________