

ST. MATTHEW'S SCHOOL HEALTH FORM

Child's Name _____ Birthdate _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical attention at the time of an illness or accident, I hereby authorize the staff to take my child to Physician _____ Address _____ Phone _____ OR to his substituting physician OR to any hospital. I give my consent for whatever first aid treatment that may be necessary for my child while he/she is in the School's care.

Communicable diseases child has had _____ Any allergies, existing illness, previous illness or injuries, hospitalizations during the past 12 months, any medication prescribed for long term continuous use, or other conditions affecting the treatment of my child are listed here: _____

I will update this and other such information as needed.

_____ X _____
Date Signature of Parent or Guardian

IMMUNIZATIONS AND DATES GIVEN --- THIS NEEDS TO BE FILLED OUT BY THE PHYSICIAN:

DTP or TD _____

OPV/IPV _____

MMR _____

HIB _____

Hepatitis A _____

Hepatitis B _____

PCV 7 _____

Varicella _____

VISION: Date _____ Type of screening _____ Screener's Name _____
Results R _____ L _____

HEARING: Date _____ Type of screening _____ Screener's Name _____
Results R _____ L _____

This child has at least begun to receive the required immunizations, and all will be completed as soon as is medically feasible. This child _____ has been examined by a licensed physician within the past year, or has been examined in a clinic or health program. This child is physically able to take part in the school program.

_____ X _____
Date Signature of Physician