



COVENANT PRESBYTERIAN PRESCHOOL & CDO

MEDICAL FORM 2018-2019

(Due back to the Preschool by August 1st. Completed form may be faxed to 512-334-3091.)

Child's Name _____ Birth Date ____/____/____

Age on Sept. 1, 2018 _____

IMMUNIZATIONS (Please list month, day, year!!)

NOTE: If you are delaying or opting out of any vaccinations, even under doctor recommendations, you must submit a notarized affidavit from the Texas Dept. of State Health Services. Your doctor must still complete the bottom portion of this form to be turned in with the affidavit.

http://www.dshs.state.tx.us/immunize/docs/faq_exemption.pdf

Diphtheria/Tetanus/Pertussis (DTaP) (List all dates, not just booster dates.)

- 1. _____ 2. _____ 3. _____ 4. _____ (all 4 doses must be completed by 15 months)
- 5. _____ (Past fourth birthday booster)

POLIO (OPV or IPV)

- 1. _____ 2. _____ 3. _____ Booster _____ (One booster past 4th birthday)

MMR (Measles, Mumps, Rubella)

- 1. _____ (On or after 1st birthday; before 15 months)
- 2. _____ (Must be given at least 30 days after 1st MMR or by age 5)

HibCV or Hib PV 1. _____ 2. _____ 3. _____ 4. _____
(Primary Series or one shot past 15 months)

VARICELLA (Chicken Pox) _____

HEPATITIS A _____

HEPATITIS B _____

PNEUMOCOCCAL (PCV) _____

OTHER _____

CHRONIC CONDITIONS _____

ALLERGIES, SPECIAL DIET, RESTRICTIONS OF PHYSICAL ACTIVITY, SPECIFIC MEDICATION, ETC. _____

NONE

Mandatory for 4-and 5-year-olds

HEARING	Date _____	Signature _____				
Hz	250	500	1000	2000	4000	6000
Right	_____					Pass _____
Left	_____					Fail _____
25 dB	1000	2000	4000			
Right	_____					Pass _____
Left	_____					Fail _____

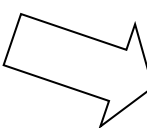
VISION Date _____ Signature _____
Right: 20/____ Left: 20/____ Pass: _____ Fail: _____

Is this child able physically and mentally to participate in group activities? _____
I have examined _____ within the past 12 months and find her/him free of infection and communicable diseases and able to participate in all programs offered in the Covenant Presbyterian Preschool at the Covenant Presbyterian Church.

Signature of Doctor _____ Date _____

Phone # _____ Address _____

TO BE FILLED OUT BY YOUR DOCTOR





AUTHORIZATION FOR EMERGENCY MEDICAL CARE

In the event I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give my permission for: COVENANT PRESBYTERIAN PRESCHOOL & CDO Director or person in charge to care of my child.

Name of Child: _____

Date of Birth: ____/____/____

Name of Parents: _____

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY!!!!!!!

HOSPITAL INFORMATION:

Hospital Name: Dell Children's Medical Center Hospital's Telephone: 512-324-0000
Hospital Address: 4900 Mueller Blvd. Austin 78723

MEDICAL INFORMATION:

Physician's Name: _____ Physician's Telephone: _____
Physician's Address: _____
Medication(s) Taken: _____

HEALTH HISTORY (check all those that apply)

- Frequent ear infections Chicken pox Measles Frequent Colds / Sore Throats Mumps
- Sinusitis / Bronchitis Strep Throat German Measles Mononucleosis Whooping Cough
- Insect Stings Hay Fever, etc. Heart Defect / Disease Tuberculosis Constipation
- Poison Ivy/Oak/Sumac Epilepsy / Convulsions Polio Fainting Bedwetting
- Bleeding / Clotting Disorders Sleep Walking Asthma Stomach Problems

MEDICAL INSURANCE INFORMATION:

Insurance Company Name: _____ Insurance Telephone: _____
Insured's Name: _____ Insured Number / Member Id: _____
Group ID #: _____ Employer Name: _____

DENTAL INFORMATION:

Dentist's Name: _____ Dentist's Telephone: _____
Dentist's Address: _____

DENTAL INSURANCE INFORMATION:

Dental Insurance Company Name: _____ Dental Insurance Telephone: _____
Insured's Name: _____ Insured Number / Member Id: _____
Group ID #: _____ Employer Name: _____

I give consent for necessary emergency treatment when my child is in the care of this physician, dentist or hospital. I give permission to transport my child for emergency care.

Signature of Parent or Legal Guardian

Date