COVENANT PRESBYTERIAN PRESCHOOL
MEDICAL FORM 2019-2020

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

Child's Name _____ **Birth Date** ___/___/___

TO BE COMPLETED BY YOUR DOCTOR

IMMUNIZATIONS (Include 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 ☐

This portion is 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: _____

Form will not be accepted without this section completed by your doctor.

Is this child able physically and mentally to participate in group activities? _____
I have examined _____ within the past 12 months and find him/her 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** _____

Office Address & Phone _____

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 the Covenant Presbyterian Preschool & Child's Day Out Director or person in charge to care for my child.

Name of Child: _____ Date of Birth: ____/____/____

Name of Parents: _____

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