

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:

DTPorTD	_____	_____	_____	_____	_____
Oral Polio	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
PCV7	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____

VISION RESULTS R _____ L _____

HEARING RESULTS _____

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