UNIVERSITY CHRISTIAN CHURCH WEEKDAY SCHOOL
Pre-School Health Record

PLEASE NOTE:
1. Each child is required to have been examined within the year prior to admission.
2. This form **MUST** be in your child's file in the office **BEFORE** your child may be admitted to class.
3. Please complete both sides of this form if you are **NEW** to WDS.
4. This (confidential) form will be kept in a file in the WDS office, available to administrators and regulatory authorities.
5. All families attach most up to date shot record.

To be completed by parents:

Child's Name: _____ Age: _____ Birthdate: _____ Sex: M F

Parent's Name: _____ Phone: _____

Address: _____

Health History: (If answer is "yes", please explain).

Any physical or mental impairments? _____

Any recent serious illnesses? _____

Any chronic illness/hospitalizations? _____

Any allergies? _____

Any medication prescribed on a regular basis? _____

Any other recent medical changes we need to be aware of? _____

Has this child been toilet trained? Yes No

Are there any parent concerns? _____

Is your child up to date on current vaccinations? Yes/ No , if no, please explain _____

_____

PARENT'S AUTHORIZATION FOR EMERGENCY MEDICAL CARE

In the event I cannot be reached to make arrangements for emergency medical care at the time of an illness or accident for my

child, _____, I hereby authorize the adult(s) in charge to take my child to:

_____
(Name of Physician) (Address) (Phone)

_____
(Name of Hospital) (Name of another licensed physician)

In the event the above physicians cannot be reached, I authorize the adult(s) in charge to consent to medical treatment from the best available source.

_____
(Date) (Signature of Parent or Legal Guardian)

PLEASE HAVE YOUR CHILD'S PHYSICIAN COMPLETE THE BACK OF THIS FORM
TO BE COMPLETED BY CHILD'S PHYSICIAN

Please complete the following chart and sign below or attached a **signed** computerized shot record.

IMMUNIZATION RECORD

VACCINES	*DATE*	*DATE*	*DATE*	*DATE*	*DATE*
DTP, DT, Td					
OPV, IPV					
Measles	VACCINE			ILLNESS	
Mumps	VACCINE			ILLNESS	
Rubella	VACCINE			ILLNESS	
HIB, HIBCV					
TB Test					
Hepatitis B					
Hepatitis A					
Pneumococcal					
Varicella*					

THE ABOVE PATIENT HAS BEEN EXAMINED BY ME, FOUND TO BE FREE OF ANY CONTAGIOUS DISEASE, FULLY IMMUNIZED, AND ABLE TO PARTICIPATE IN ALL SCHOOL ACTIVITIES.

(PHYSICIAN=S SIGNATURE REQUIRED BY STATE LICENSING.)

_____
Physician's Signature Date

_____
Street Address, City/State/Zip Phone

* If the child has had the varicella disease (chickenpox), please indicate below:

This is to verify that _____ had the varicella disease (chickenpox) on or about the given date and does not need the varicella vaccine.@

_____ _____
Signature Relationship to student

_____
Date of disease