St. Luke's DAY SCHOOL

MEDICAL INFORMATION FORM

Instructions: Please print and complete **all** blanks and return **two** copies of this form.

- **Date of last well check, physician's signature** and **updated immunization record are required**.
- **Insurance information** and **parent's signature are required** under "Parent Authorization for Emergency Medical Treatment."

Child's Name _____ Birth Date _____ Gender _____

Doctor's Name _____ Doctor's Phone _____

Doctor's Address _____
Street Suite Zip

___ **Updated Immunization Record attached**

Please check any of the following special problems this child may have/have had:

____ allergies*
____ existing illness
____ previous serious illness
____ other info of which the school staff should be aware

____ injuries during the past 12 months
____ medication prescribed for long-term use
____ hospitalizations during past 12 months

*please request a Food Allergy Action Plan form, if applicable

If any of the above are checked, please explain: _____

_____

_____

I have examined the above named child on _____ (**date of last well check**) and found that he/she is physically able to take part in the Day School program.

_____ _____
Physician's Signature **Date**

For office use only: Well check date on file: Yes ____ No ____ Immunization Record on file: Yes ___ No ___

PARENT AUTHORIZATION for EMERGENCY MEDICAL TREATMENT

Child's Name _____

Family Health Insurance: _____ Group # _____
ID # _____

In the event I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to the recommended hospital or to his/her doctor.
I give my consent for necessary emergency treatment.

Parent's Signature: _____