St. Luke's DAY SCHOOL
PLAYING & LEARNING TOGETHER

MEDICAL INFORMATION FORM

Please complete top section. Date of last well check and physician's signature are required. Updated immunization record required and may be submitted separately.

Child's Name _____

Date of Birth _____ Gender ◯ Male ◯ Female

Doctor's Name _____

Doctor's Phone _____

Doctor's Address _____
Street, Suite, City, Zip

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

- ☐ allergies*
- ☐ existing illness
- ☐ previous serious illness
- ☐ other info school staff should know
- ☐ injuries during the past 12 months
- ☐ medication prescribed for long-term use
- ☐ hospitalizations during past 12 months

*If an EPI Pen is prescribed, an Allergy Action Plan is required.

If any of the above are checked, please explain:

_____

_____

_____

Health Statement: I have examined the above-named child and found that he/she is physically able to take part in the Day School program.

Date of last well check: _____

_____ _____

Physician's Signature **Date**

Print Save Reset