schick's crossing
PRESCHOOL
MEDICAL FORM

CHILD'S NAME:

DOCTOR'S NAME:	PHONE:

HOSPITAL AFFILIATION:

MEDICAL HISTORY

IS YOUR CHILD UNDER ROUTINE MEDICAL CARE? **YES** **NO**

DOES YOUR CHILD HAVE ANY ALLERGIES? **YES** **NO**

IF YES, PLEASE LIST:

DOES YOUR CHILD HAVE ANY MEDICAL/PHYSICAL PROBLEMS? **YES** **NO**

IF YES, PLEASE LIST:

DOES YOUR CHILD HAVE ANY VISION/HEARING PROBLEMS? **YES** **NO**

IF YES, PLEASE LIST:

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES/INJURIES IN THE PAST YEAR? **YES** **NO**

IF YES, PLEASE LIST:

MEDICAL EMERGENCIES

IN CASE OF A MEDICAL EMERGENCY, WHO SHOULD WE CONTACT IF PARENTS CANNOT BE REACHED:

NAME:	PHONE:
NAME:	PHONE:

EVERY STUDENT MUST HAVE A COMPLETED DHS PHYSICAL EXAMINATION FORM AND BIRTH CERTIFICATE ON FILE BY THE FIRST DAY OF SCHOOL.

As a parent/guardian, I authorize treatment by a qualified licensed medical doctor for my child in the event of a medical emergency. I also authorize qualified preschool staff to administer CPR and/or First Aid if necessary for the health and safety of my child.

PARENT SIGNATURE:	DATE:

PLEASE USE THE BACK SIDE OF THIS PAGE TO ELABORATE IF NECESSARY