# Health Form 2021 – 2022

## Cross of Christ Preschool and Kindergarten

**Please return this completed form to the school **no later than May 5, 2021. Health and immunization forms MUST be received by the school before your child can attend Summer Camp or School.** All children enrolling after May 5, 2021 **MUST** return the health and immunization forms **within 30 days of enrollment.***

**PARENT please complete AND SIGN**

Child's Name: _____ Birthdate: _____

Allergies: ☐ None or Describe _____

Type of reaction: _____

Will there be an epi-pen, inhaler, or other medication kept at school? ☐ Yes ☐ No

Diet: ☐ Age Appropriate ☐ Special Diet _____

I, _____, give consent for my child's health care provider or school personnel to discuss my child's health concerns. My child's health provider may email this form (and applicable attachments) to my child's school or child care. Email: preschool@cross-of-christ.org

Parent or Guardian's Signature_____ Date: _____

**HEALTH CARE PROVIDER: Please compete after Parent Section Competed**

**Date of Last Health Appraisa**l: _____ **Weight at Exam**: _____

**Physical Exam**: ☐ Normal ☐ Abnormal (describe) _____

If Tuberculin Test Given: Date _____ Result_____

**Significant Health Concerns:** ☐ Life Threatening Allergies ☐ Non-Life-Threatening Allergies ☐ Asthma ☐ Dietary Restrictions ☐ Reactive Airway Disease ☐ Seizures ☐ Diabetes ☐ Hospitalizations ☐ Developmental Delays ☐ Vision ☐ Hearing ☐ Dental ☐ Behavior Concerns ☐ Nutrition ☐ Other: _____

**Current Special Diet/Medications:** ☐ None or Describe _____

*Separate medication authorization form is required for medications given in school or child care

**Immunizations**: ☐ Up-to-Date ☐ See attached immunization record ☐ Administered today: _____

**Restrictions**:

Activity_____

Diet_____

Other_____

**Next Well Visit Due**: _____

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

This child is healthy and may participate in all routine activities in child care or preschool. Any concerns or exceptions are identified on this form.

**Physician's Name**_____

**Address**_____**Phone**_____

_____

_____**Date**_____

**Signature of Health Care Provider** (certifying form was reviewed)