TO BE COMPLETED BY THE PARENT/GUARDIAN

PLEASE ADD ANY ADDITIONAL INFORMATION ON BACK OF FORM

Student's Last Name **First Name** **Age Level**

Birthdate: _____ **Male:** ☐ **Female:** ☐

Medical History (check all that apply)

☐ Glasses ☐ Seizures ☐ Ear Tubes ☐ Sensitive Skin

☐ Asthma ☐ Heart Condition ☐ Eczema ☐ Food Sensitivities

Medication Allergies: _____

Food Allergies: _____

Seasonal Allergies: _____

☐ Epi Pen

☐ Inhaler

If you checked "Yes" to either Epi Pen of Inhaler, see Nurse Abi for additional paperwork to be filled out by your child's doctor and returned to Chapelwood School by August 31, 2022 in order for your child to start on the first day of school.

Health/Medical Concerns or Recent Hospitalization:

_____

Prescription and Over-The-Counter Medicines taken at *Home*:

_____

Daily School Medicines:

_____

Generic Over The Counter Medications (check all that apply)

Parents to supply medicine for student use at Chapelwood School. Medicine to be administered per product label only.

☐ Tylenol ☐ Ibuprofen ☐ Orajel ☐ Neosporin

☐ Hydrocortisone 1% Cream ☐ Benadryl Cream ☐ Diaper Rash Cream

Child's Doctor: _____ **Phone:** _____

Insurance: _____ **Policy #:** _____

HEALTH INFORMATION RELEASE

I have read and agree the information on this form, with any initialed changes, is correct. I give permission for the information on this health form to be shared with school personnel on a need to know basis in order to provide appropriate services for my child. I give permission for the nurse at Chapelwood School to contact my child's doctor in order to discuss any medical issues or information regarding my child. I agree to notify the school of any changes in my child's health status.

EMERGENCY TREATMENT RELEASE

In the event of an emergency, I give permission for treatment of my child by school personnel, nurse and/or physician. The school will notify parents as soon as possible.

PARENT'S SIGNATURE: _____ **Date:** _____

TO BE COMPLETED BY A PHYSICIAN

PLEASE ATTACH CURRENT IMMUNIZATION RECORD

Vaccines	Date	Date	Date	Date	Date
DTP, DTaP, DT, Td					
POLIO (IPV)					
HIB					
PNEUMOCOCCAL (PCV/PREVNAR)					
HEP A					
HEP B					
VARICELLA (VAR)					
MMR					

Please attach

Annual Physical Exam To Be Completed By A Physician

Within Normal Limits?

Exam	Yes	No
Cardiovascular		
Abdomen		
Neuro		
Respiratory		
GU		
Musculoskeletal		
HEENT		
Skin		

Height: _____ **in.** **Weight:** _____ **lbs.**

(circle one)

Does this child have any physical limitations? Yes or No

If Yes, explain: _____

_____

_____

Doctor's Name: _____ **Phone:** _____

Address _____

Physical Exam Date: _____ **DUE TO SCHOOL BY AUGUST 8, 2022**

Required by Chapelwood School for Young Children to be able to attend the first day of school.

I certify, that on the date noted above, I have examined the student and recommend him/her as being physically able to participate in all school activities.

PHYSICIAN'S SIGNATURE: _____ **Date:** _____