

**ST. LUKE'S DAY SCHOOL
MEDICAL INFORMATION FORM
713-402-5030**

MEDICAL FORM. Please type or print and complete all blanks. Return both copies of this form.

Child's Name _____ Birth Date _____ Gender _____

Doctor's Name _____ Phone _____

Doctor's Address _____
Street Suite Zip

Immunizations	Date 1 st Dose	Date 2 nd Dose	Date 3 rd Dose	Date 1 st Booster	Date 2 nd Booster
DTP					
Polio					
HibCV					
Pneumococcal					
Hepatitis A					
Hepatitis B					
MMR				Doctors verification must be submitted:	
Measles				Measles	Date of Illness:
Varicella				Mumps	Date of Illness:
				Chicken Pox	Date of illness:
TB Skin Test	Date Given:	Date Read:	Result:		

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

<input type="checkbox"/> allergies	<input type="checkbox"/> injuries during the past 12 months
<input type="checkbox"/> existing illness	<input type="checkbox"/> medication prescribed for long-term use
<input type="checkbox"/> previous serious illness	<input type="checkbox"/> hospitalizations during past 12 months
	<input type="checkbox"/> other info of which the school staff should be aware

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

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: _____

Subscribed and sworn to before me this _____ day of _____, _____

(Notary Public Seal)

Notary Public _____
Harris County, Texas