THE COUNTRY KINGDOM

STUDENT HEALTH AND MEDICAL RECORD

Child's Name: ______________________________Date of Birth:__________________

Address:______________________________________Telephone:_________________

Please fill out this page completely, then take it to your physician or usual source of medical care (clinic, health center, etc.) for the examination or written statement that the student has been examined within the previous twelve (12) months.

The daily program of The Country Kingdom involves both vigorous and quiet indoor and outdoor play, including the use of climbing equipment. A midmorning snack is served, usually fruit juice and crackers.

Does this child have any physical condition (including existing illness, previous illness and injuries) that we should be aware of?

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____

Is this child subject to or have difficulty with any of the following?

_____Asthma _____Diabetes _____Convulsions
_____Fainting Spells _____Heart Trouble _____Seizures
_____Allergies _____Digestion _____Ears, Eyes, Nose,
_____Throat
Other Describe____

____

Has this child been hospitalized for any reason in the past 12 months?_______________

____

____

Does this child require special attention, medication or routines that may have to be taken into consideration in planning for his time at The County Kingdom? _________________

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In your opinion, is this child physically and emotionally able to participate in a program like the one described above?____

The Country Kingdom will not be responsible for anything that may happen as a result of false or incomplete information given on this form.

Parent Signature_____________________________________ Date______________________

ALL INFORMATION MUST BE KEPT CURRENT AND ON FILE AT TCK

Child's Name: ________________________________Birth date:____________________

PHYSICIAN'S STATEMENT

	Date 1st Dose	Date 2nd Dose	Date 3rd Dose	Date 1st Booster	Date 2nd Booster
DtaP/DTP	_________	_________	_________	_________	_________
HEPATITIS A	________	_________			
HEPATITIS B	________	_________	_________	_________	_________
HIB	_________	_________	_________	_________	_________
MMR	_________	_________			
IPV/OPV	_________	_________	_________	_________	_________
PREVNAR	_________	_________	_________	_________	_________
VARIVAX	_________	_________			

Has this child had chickenpox? No_____ Yes _____
If yes, Date:_________________ (Required by State of TX)

IMMUNIZATIONS ARE TO BE KEPT CURRENT AND ON FILE AT TCK

This child was examined by me on ____________________________(date) and found to be free from all contagious and transmissible diseases and is physically able, with exceptions noted, to participate in the school program.

Physician's Signature:____

Telephone Number:____

Date:____________

BOTH SIDES MUST BE COMPLETED