Medical Information & Consent Form

Child's name: _____ **Date of birth:** _____/_____/_____

ALLERGIES: ___ No ___ Yes **EPI PEN:** ___ No ___ Yes **INHALER / NEBULIZER:** ___ No ___ Yes

Anything listed here needs to be supported by a healthcare professional *in writing* (Physician or Licensed Dietitian).

Describe the child's health (including allergies, physical and/or medical considerations, recent illnesses) that may have affected, or may affect their performance in school:

_____

_____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached during a medical emergency, I hereby give the staff at **Country Day School of Arlington** authorization to make arrangements for emergency medical care. I authorize emergency medical personnel or the person in charge to take my child to:

PHYSICIAN: _____ Phone #: _____

Address: _____

Preferred **HOSPITAL**: _____ Phone #: _____

Address: _____

I give consent for the facility to secure any and all necessary medical care for my child.

Parent / Guardian Signature: _____ Date: _____/_____/_____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN **CDSA FAX: 817-275-0263**

★Please **attach** immunization records or fill in the chart below. **Physician signature and date required.**

	DATE 1st dose	DATE 2nd dose	DATE 3rd dose	DATE 1st booster	DATE 2nd booster
Hepatitis B (HepB)					
Diphtheria, Tetanus, Pertussis (DTaP)					
Haemophilus influenza b (Hib)					
Pneumococcal (PCV)					
Inactivated Poliovirus (IPV)					
Influenza					
Measles, Mumps, Rubella (MMR)					
Varicella					
Hepatitis A (HepB)					

TB Test Date: _____/_____/_____ Results: _____

★**Any vaccine exclusion for medical reasons requires physician documentation.** If positive, physician statement is necessary for admission. Results from vision and hearing screening are required for students 4 years and older. Attach additional documentation if necessary.

Vision Screening: _____/_____/_____ Hearing Screening: _____/_____/_____

This child was examined by me on _____/_____/_____ and is physically able to participate in the school program. *Exceptions are noted on the back of this form.*

Physician's signature: _____ Phone _____

Required Document

COUNTRY DAY SCHOOL OF ARLINGTON
MONTESSORI PROGRAM
established 1959