The Little School at Memorial Drive Presbyterian Church

MEDICAL INFORMATION

Child's Name **Date of Birth**

DOCTOR'S STATEMENT: I have examined the above-named child within the past year and find that he/she is physically able to take part in a school program.

Physician's Signature **Date**

A COPY OF YOUR CHILD'S MOST RECENT IMMUNIZATION RECORD MUST ACCOMPANY THIS FORM AND BE SUBMITTED TO THE LITTLE SCHOOL OFFICE PRIOR TO THE FIRST DAY OF SCHOOL.

MEDICAL HISTORY (may be completed by parents):

Previous hospitalization? Yes No If yes, why?

Allergies? Yes No
If yes, what are they, and what are the reactions?

Previous diseases or illnesses? Yes No If yes, what?

Operations? Yes No
If yes, please describe:

Physical handicaps? Yes No
If yes, please describe:

History of convulsions? Yes No

History of heart trouble? Yes No

Congenital problems? Yes No

Need for daily and/or long term medication? Yes No
If yes, please describe:

By signing below, I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

PARENT SIGNATURE ______________________________

For additional information regarding immunizations, contact the Department of State Health Services: www.dshs.state.tx.us/immunize/school_info.htm