

## HEALTH REQUIREMENTS

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ADMISSION REQUIREMENT: **One of the following** must be presented when child is admitted into St. James Episcopal School or within one week of admission. Check to indicate the option you select:

☐ 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 the day care program.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

☐ A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated

☐ A form or written statement from a health service or clinic

NOTE: If medical diagnosis and treatment and/or immunization conflict with your religious beliefs, you must sign an affidavit to the effect and attach it to the form. Please see office for details. If immunization would be injurious to your child or family, you must obtain a certificate (signed by your physician) to that effect and attach it to this form.

### Health Information

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

- Are there any physical, emotional or medical concerns of which the school should be aware? Y N

If yes, please explain: \_\_\_\_\_

- Has there been any illness or change in the usual routine or environment recently that may have affected your child? Y N If yes, please explain: \_\_\_\_\_

- Is your child on routine medication? Y N If yes, what? \_\_\_\_\_

- Allergies:

Food: \_\_\_\_\_

Other: \_\_\_\_\_

- Emotional Development:

Fears? \_\_\_\_\_ Jealousy? \_\_\_\_\_ Thumb-sucking? \_\_\_\_\_

- Birth weight? \_\_\_\_\_

- Full Term? Y N

- How old was your child when he/she walked? \_\_\_\_\_

Is your child (check applicable) right-handed? \_\_\_ left-handed? \_\_\_ Not sure at this time? \_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_