THE SLOAN SCHOOL
3131 N. O'Connor
Irving, Texas 75062
972-659-1199

Health Record

DATE OF ADMISSION

CHILD'S NAME (LAST) (FIRST) (M.I.) | DATE OF BIRTH

NAME OF PERSON WITH WHOM CHILD LIVES

CHILD'S PHYSICIAN | TELEPHONE

PHYSICIAN'S ADDRESS STREET STATE ZIP

FOOD ALLERGIES/HEALTH PROBLEMS | SEVERITY: MILD/MODERATE/SEVERE | TREATMENT INSTRUCTIONS

MEDICINES CHILD IS TAKING

CHILD'S DENTIST | TELEPHONE

CHILD'S SPECIALIST | TELEPHONE

HAS YOUR CHILD HAS ANY OF THE FOLLOWING:

❑ Convulsions ❑ Kidney Ailment ❑ Diabetes ❑ Bronchitis ❑ Heart Ailment ❑ Tuberculosis ❑ Epilepsy ❑ Asthma ❑ Hospitalized within the past year

INSURANCE INFORMATION - NAME OF COMPANY

INSURANCE TELEPHONE | POLICY NUMBER

I declare that I have legal custody of the above named child/children and I authorize The Sloan School to consent any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of Texas when the need for such treatment is immediate, and when efforts to contact me are unsuccessful. I give permission for my child to ride a bus or walk to or from school or home, or to be released to the care of a sibling under 18 years old, if applicable.

PARENTS'S SIGNATURE _____

If a medical emergency occurs and I cannot be reached, I hereby authorize the person in charge at The Sloan School to transport my child to the nearest medical clinic and/or call my family physician and give permission for any treatment deemed necessary by a licensed physician and/or hospital. ❑ YES ❑ NO

I give permission to The Sloan School to administer sunscreen on my child during the Spring and Summer months before outdoor play every day.

PARENT'S SIGNATURE | DATE

HOURS IN CARE | PUBLIC SCHOOL | TELEPHONE

IMMUNIZATIONS A copy of your child's current shot record is required before he/she can attend school.

POLIO: Dose 1st ____/____/____ 2nd ____/____/____ 3rd ____/____/____ 4th ____/____/____ 5th ____/____/____

PDT: Dose 1st ____/____/____ 2nd ____/____/____ 3rd ____/____/____ 4th ____/____/____ 5th ____/____/____

MMR: ____/____/____ T. B. ____/____/____ HIB ____/____/____ OTHER: _____

Vision/Hearing screening is required for all children ages 4 and over. Please attach your child's most recent screening results.

Date of last physical: _____

This child has been examined within the past twelve months and is physically able to participate in the activities of this school.

PHYSICIAN'S SIGNATURE DATE