

**Children of Joy! Preschool**  
2020-2021 Student Medical Record

Child's Name \_\_\_\_\_

DOB \_\_\_\_\_

Please answer each question **completely**. State of Texas Licensing requires that all medical information below must be on file at the Preschool before a child can be admitted to the school. **Incomplete Medical Forms will not be accepted.**

**Immunization Record:**

\_\_\_\_\_ Attached is a copy of my child's most current immunization record.

My child has had chickenpox disease and is not required to have the Varicella vaccine. \_\_\_\_ Yes \_\_\_\_ No

**If** your child has had chickenpox, please complete the following statement: My child had varicella disease (chickenpox) on or about (date) \_\_\_\_\_ and does not need the varicella vaccine.

\_\_\_\_\_

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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 ([www.dshs.state.tx.us/immunize](http://www.dshs.state.tx.us/immunize)). I understand this affidavit is valid for 2 years. \_\_\_\_ Yes \_\_\_\_ No

My child, \_\_\_\_\_, has been examined by \_\_\_\_\_,  
\_\_\_\_\_ (name and address of physician) on the above mentioned date and has been found to be free of existing illness and is able to participate in preschool activities.

\_\_\_\_\_

**Parent Signature**

\_\_\_\_\_

**Date**

**Health Care Professional's Statement (to be completed by physician):**

Date of Last Physical Examination \_\_\_\_\_ .

Does the child have an existing illness, take medication for long term use, or is subject to seizures, allergies or any other medical condition that would restrict normal preschool activities? \_\_\_\_ Yes \_\_\_\_ No

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

I have examined the above named child **within the past year** and find that he/she is able to participate in the preschool program. I also hereby certify that the above referenced information in regards to Immunizations is correct.

\_\_\_\_\_

**Physician Signature**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Physician Name**

\_\_\_\_\_

**Phone Number**

**Continue on back**

### Authorization for Emergency Medical Attention:

In the event that I cannot be reached to make arrangements for emergency medical care, I authorize the facility director or staff person in charge to take my child to:

Child's Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Physician's Address \_\_\_\_\_ Hospital Preference \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Company Policy # \_\_\_\_\_ Insured 's Name \_\_\_\_\_

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

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

### Health History

Has your child had any previous serious illness or hospitalization? \_\_\_\_ Yes \_\_\_\_ No

If yes, briefly explain: \_\_\_\_\_

Is your child receiving on going care from a specialist (speech, ECI, other)? \_\_\_\_\_ Yes \_\_\_\_ No

If yes, please provide details: \_\_\_\_\_

Is your child taking any prescription medications? \_\_\_\_ Yes \_\_\_\_ No

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

Does your child have any special needs? \_\_\_\_ Yes \_\_\_\_ No

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

Does your child have any allergies? \_\_\_\_ Yes \_\_\_\_ No

If yes, please be specific as to reactions and severity: \_\_\_\_\_

*\*For children with allergies, an Allergy Plan Form (provided by COJ) must be completed by a physician and kept on file at the preschool as required by licensing.*

### PERSONS AUTHORIZED TO PICK UP CHILD OR TO BE CALLED IN CASE OF AN EMERGENCY

A child will be released only to parents or to an adult designated in writing by a parent. A staff member must be aware of a child's departure. Please list persons who have your permission to pick up your child, and who can be contacted in case of an emergency if you cannot be reached. Please be certain that the people you list are willing to pick up your child in case of illness or emergency. **COJ! REQUIRES at least one contact person (other than parents) on file for your child.** I hereby authorize the following person(s) to leave the child care facility with my child:

1. Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Relationship \_\_\_\_\_

2. Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Relationship \_\_\_\_\_

3. Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date