POLKA DOT PRESCHOOL
CHILD MEDICAL RECORD

CHILD'S NAME: ________________________ DATE OF BIRTH: ______________________

Address: ____

Child's Physician: ________________________________ Phone: ________________________

Child's Specialist: ________________________________ Phone: ________________________

Does your child have any physical disabilities?

☐ Yes (please describe): ____

____

☐ No

Does your child suffer from:

◯Asthma

◯Hay Fever

◯Skin Allergies ___________________________________

◯Food Allergies __________________________________

◯Other (specify) _________________________________

When, if ever, did your child have:

German measles (rubella)______________________ Mumps: _______________________

Regular measles (rubcola) ____________________ Pneumonia: ____________________

Whooping cough:____________________________ Pneumatic fever: _______________

Does your child regularly take any medication?

◯Yes (specify) ____

____

◯No

The Chief Medical Officer of Health requires that all students be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella and Haemophilus B Meningitis.

Is there any medical, religious or philosophical reason why your child should not receive immunization?

◯Yes (please explain) ____

____

◯No

Please fill in the chart below, or attach a photocopy of your child's immunization record.

Dates: d/m/y							
Pertussis							
Diphtheria							
Tetanus							
Polio							
Oral Polio							
Measles							
Mumps							
Rubella							
Chicken Pox							
TB Skin Test Result:							
BCG							
Haemophilus B Polysaccharide (Hib)							
Other (specify)							

PHYSICAL EXAMINATION

Weight ___________________ Height ___________________________

__________________________________ has been examined by me and is physically able to
(Child's Name)
attend Polka Dot Preschool, and is free from communicable diseases.

While she/he is at Polka Dot Preschool, I recommend as follows, in view of allergies and other conditions:

____

____

____

____

____

Date: _______________________

Physician or Parent Signature: ______________________________

POLKA DOT PRESCHOOL
CONSENT FORM FOR EMERGENCY MEDICAL TREATMENT

Name of Child: ____

Birth Date: ____________________________________

In an emergency, every effort will be made to contact the parents or guardian of the child involved. However, if, at any time, emergency medical treatment is required due to such circumstances as accidents, sudden illness, or another emergency, such medical treatment may be given a private physician or hospital. This includes anaesthetic if necessary.

Signature of Parent or Guardian: ___________________________________

Date: _______________________

Signature of Witness (non-family member) ____________________________

POLKA DOT PRESCHOOL
CONSENT FOR FIELD TRIPS

I, ______________________, hereby consent to have my child, _________________________
(Parent's Name)
leave the premises of Polka Dot Preschool in order to participate in occasional excursions to places of interest, which would be planned as part of the children's program.
It is understood, that supervision will be provided by members of the Polka Dot Preschool Staff and Parent Volunteers.

Signature of Parent or Guardian: ___________________________

Date: __________________________

Signature of Witness (non-family member): _____________________________