GOOD SHEPHERD LUTHERAN SCHOOL & CHILD CARE
East Troy, Wisconsin, 53120

CHILD HEALTH RECORD

NAME _____ _____ ___M___F___
Last First Middle Initial Birthdate Sex

PARENTS _____ _____
Name Address

_____ _____ _____
Telephone Emergency Telephone Date of School Entry

_____ _____
Doctor's Name Dentist's Name

_____ _____
Doctor's Address Dentist's Address

SIGNIFICANT FAMILY HEALTH HISTORY (PARENTS AND SIBLINGS)

_____Allergies _____Tuberculosis _____Cancer _____Diabetes

_____Heart Disease _____Kidney Disorder _____Nervous Disorder _____Mental Disorder

_____Other (please specify) _____

SIGNIFICANT PERSONAL HISTORY (CHILD)

	AGE		AGE		AGE
_____Congenital Defects	_____	_____Mumps	_____	_____Kidney Disorder	_____
_____Bone and joint	_____	_____Measles	_____	_____Hearing Problems	_____
_____Rheumatic fever	_____	_____Chicken Pox	_____	_____Vision Problems	_____
_____Heart Disorder	_____	_____Scarlet Fever	_____	_____Other (please specify)	
_____Convulsions or Seizures	_____	_____Whooping Cough	_____	_____	
_____Asthma	_____	_____Poliomyelitis	_____	_____	
_____Diabetes	_____	_____Tuberculosis	_____		
_____Frequent Strep Infections	_____	_____Epilepsy or Seizures	_____	_____Hospitalizations (specify)	
_____Frequent Colds	_____	_____High Blood Pressure	_____	_____Date: _____	
_____Ear Infections	_____	_____Muscular Disorder	_____	_____Date: _____	

If any preceding conditions were checked, please give special instructions for care: _____

_____

Is your child receiving medication? _____ If so, please explain: _____

_____

PARENTS AUTHORIZATION AND SIGNATURE

I HEREBY AUTHORIZE:
1. Release of above information to all Good Shepherd Lutheran School & Child Care Personnel and School Bus Drivers.
2. The Principal or other School Personnel to call the Physician or Dentist named above if an emergency exists, or it necessary an alternate doctor.
3. Permission for transporting my student if in need of emergency care.

Date _____ Signature of Parent _____

(Over, please)

PHYSICAL EXAMINATION

Height_____ _____% Weight_____ _____% Blood Pressure_____

	Normal	Abnormal
Skin		
Eyes		
Ears		
Nose & Throat		
Mouth		
Dental		
Neck		
Heart		
Lungs		
Abdomen		
Hernia		
Extremities		
Nutritional Status		
Emotional Status		

Comments _____

Do you wish to see this child again?_____ If so, when?_____

Are you referring this child to another professional?_____ If so, whom? _____

Is this child on any medication?_____ If so, what?_____

Recommendations for child's school program

_____Regular School

_____School Half-day

_____Developmental Testing*

_____Physical Therapy

_____Homebound Instruction

_____Special Seating

Comments _____

*suspected developmental delays – e.g. speech, motor development, cognitive

Date of examination _____ Signature of Physician _____

Address _____ Phone Number _____

Medical Consent

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student.

In the event of serious illness, the need for major surgery, or significant accidental injury, the attending physician will attempt to contact me. If said physician is not able to communicate with me, the treatment necessary in the best interest of the above named student may be given.

In the event that an emergency arise during a practice session, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the Emergency Medical Personnel to provide the needed emergency treatment to the student prior to his/her admission to medical facilities.

_____ _____

Signature of Parent/Guardian Date

Hospital Preference_____ Insurance Co. _____

Family Physician & Phone Number: _____ Policy No. _____

_____