



British Private Prep School

Setting The Foundation Stage

Fax to 281-828-2002

Name of child:				Date of birth:	
Immunizations	Date / dose 1	Date / dose 2	Date /dose 3	Date /dose 4	Date of booster
Hep B					
DTP/DTaP/DT					
Polio IPV or OPV					
Hib-CV					
MMR					
Hep A					
PCV Pneumococcal					
Varicella See below					
Varicella (chickenpox) vaccine is not required if your child has had the chickenpox disease. If your child has had chickenpox, please complete the statement. My child has had varicella disease on or about date _____ and does not need the varicella vaccine					
_____				_____	
Parent's signature				Date	
_____				_____	
Health care professional's signature				Date	

Hearing and Vision Test Results listed below:

VISION	R/20 _____	L/20 _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE			

HEARING	1000Hz	2000Hz	4000 Hz	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
RIGHT				
LEFT				
SIGNATURE			DATE	

Signature or stamp and name of health care professional filling out the above information.

X _____ Print name _____

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 a preschool program.

_____ Date _____
Physician's Signature

Child's Name :

In case of a *medical emergency*, I hereby grant permission for the staff at British Private Prep Schools, Ltd to administer CPR, first aid, obtain emergency medical care and/or to transport my child, (name) _____ to the nearest hospital or to call my child's physician at the following number.
Physician's Name _____
Address _____
Phone # _____
_____/_____
(Parent signature) _____ (date) _____

The name of the health care professional that examined my child within the last year is _____.
The address is _____
_____/_____
(Parent signature) _____ (date) _____

Medical History

Does your child have special circumstances or needs? yes/no (If so, explain)

Is your child allergic to any foods? yes/no (If so, explain)

Are there any foods your child will not eat simply because they do not care for them? yes/no
(If so, explain) _____
Does your child have any dietary Restrictions? yes/no (If so, explain)

Is your child allergic to insect bites or sting? yes/no (If so, explain)

Is your child currently taking any prescribed medication for continuous, long term use? yes/no
(If so, explain) _____
Does your child have any existing or previous illnesses or injuries or hospitalizations during the past 12 months? yes/no
(If so, explain) _____
Parent Signature _____