The Episcopal Day School of Evergreen

STATEMENT OF HEALTH

Child's Name: ____________________ Sex:______ Date of Birth: ____________

Past Illnesses - Check those that the child has had and give approximate dates:

Chicken Pox ____________	Rubeola ____________	Rubella ____________
Rheumatic Fever __________	Asthma ____________	Hay Fever ____________
Diabetes ______________	Mumps ____________	Epilepsy ____________
Whooping Cough __________	Poliomyelitis ________	Other ______________

Comments: ____

Surgery/Accidents/Illnesses/Chronic Health Problems: ______________________

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Describe any physical condition requiring the facilities special attention: __________

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Medication(s) prescribed: ______________________________________

Allergies: ____________________ Prescribed Routine: __________________

If tuberculin test given: Date: __________________ Results: ________________

If chest x-ray taken: Date: ____________________ Results: ________________

Vision: ______________________ Hearing: ________________________

Dentist: ____________________ Phone Number: ______________________

Dentist Address: ____

Emergency Contacts: Name: __________________ Phone Number: __________

Address: _________________________ Relationship to Child: ____________

Name: ____________________________ Phone Number: ________________

Address: _________________________ Relationship to Child: ____________

Parent/Guardian Signature: ______________________ **Date:** ____________