Medical Information & Consent Form

Child's name _____ Date of birth _____

Father: _____ Main contact # _____

Mother: _____ Main contact # _____

Allergies _____ Asthma/Hay fever _____

Medicines _____ Daily Medications _____

(Attach the prescription and dosage instructions for all medications to be administered by CDSA staff.)

Foods that the child should not eat _____

Other _____

Limitations (activities in which the child should NOT participate) _____

Water Activity _____ Field Trips _____ Outdoor Sports/Games _____

Other _____

I hereby give authority for the CDSA staff to authorize medical treatment for my child in the event that I cannot be reached to make arrangements for emergency medical attention at the time of an illness or accident.

Parent/Guardian Signature: _____ Date: _____/_____/_____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN CDSA FAX: 817-275-0263

✶Please attach immunization records or fill in the chart below. Physician signature and date required.

	DATE 1st dose	DATE 2nd dose	DATE 3rd dose	DATE 1st booster	DATE 2nd booster
Hepatitis B (HepB)					
Diphtheria, Tetanus, Pertussis (DTaP)					
Haemophilus influenza b (Hib)					
Pneumococcal (PCV)					
Inactivated Poliovirus (IPV)					
Influenza					
Measles, Mumps, Rubella (MMR)					
Varicella					
Hepatitis A (HepB)					

TB Test Date: _____ Results: _____

✶**Any vaccine exclusion for medical reasons requires physician documentation.** If positive, physician statement is necessary for admission. Results from vision and hearing screening are required for students 4 years and older. Attach additional documentation if necessary.

Vision _____ Hearing _____

This child was examined by me on _____/_____/_____ and is physically able to participate in the school program. Exceptions are noted on the back of this form.

Physician's signature _____ Phone _____

2019—2020 Required Document

COUNTRY DAY SCHOOL OF ARLINGTON
MONTESSORI PROGRAM
established 1959