



Medical Information and Consent Form

Required once every calendar year.

Child's name _____ Date of birth _____
 Father: _____ Main contact # _____
 Mother: _____ Main contact # _____

To be completed by your physician

CDSA Fax: 817-275-0263

*This child has had the following immunizations:

| | DATE 1 st dose | DATE 2 nd dose | DATE 3 rd dose | DATE 1 st booster | DATE 2 nd 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 (HepA) | _____ | _____ | _____ | _____ | _____ |

TB Test Date: _____ Results: _____

*Any vaccine exclusion for medical reasons requires physician documentation.

If positive, physician statement is necessary for admission.

Physician's signature

Phone _____

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

Results from vision and hearing screening (required for 4 year olds, Kindergarten, 1st, 3rd, 5th, and 7th grades, and all new students); attach additional documentation if necessary.

Vision _____ Hearing _____

Allergies _____ Asthma/Hay fever _____

Medicines _____ Daily Medications _____

(Please 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) _____

Swimming _____ Field Trips _____ Outdoor Sports/Games _____

Other _____

Since many of our school activities are conducted outdoors, we often find it necessary to spray insect repellent or to apply sunscreen to students. Please check the appropriate box to grant or deny permission to apply these products to your child.

I hereby -give -do not give consent for my child to receive insect repellent provided by CDSA staff.

I hereby -give -do not give consent for my child to receive sunscreen by CDSA staff.

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: _____/_____/_____