

MESSIAH LAMBS HEALTH RECORD

Phone: (972)398-7560

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Part I: Identifying Information – to be completed by parent

Child: _____
Last Name First Name Middle Name

Date of Birth: _____ Sex (Circle one): Male Female
MM/DD/YY

Doctor's Name: _____ Doctor's Telephone: _____

Doctor's Address: _____
Street City Zip

Part II: Statement Concerning Health Status

– to be completed and signed by the child's physician

Diagnosis of Physical or Mental Impairment: _____

Limited Activities (List activities in which the child should not participate): _____

Medication Prescribed on Regular Basis (Must be in original container if administered at facility): _____

Special Diet: _____

Asthma (Please describe symptoms/course of action): _____

Allergies (Please include severity of reaction): _____

I have examined the previously named Child and find that he / she is physically able to take part in school activities.

Physician's Signature

Date

Part III: Immunization Records – please attach a signed / stamped copy of the Child's immunization records