

# CHILD HEALTH RECORD –NEW CREATIONS PRESCHOOL

1500 FM 156 SOUTH OFFICE: 817-439-2100, FAX: 817-439-2100

To be completed by parent:

Child's name: \_\_\_\_\_ Sex: M F Birthdate: \_\_\_\_\_

List any recent illness: \_\_\_\_\_

List any chronic illness/condition: \_\_\_\_\_

List any allergies: \_\_\_\_\_

If child has been hospitalized in the past 12 months, please describe/explain:

\_\_\_\_\_

List any conditions for which this child may require special treatment:

\_\_\_\_\_

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## PHYSICIAN'S EXAMINATION and IMMUNIZATION RECORD

Date of Exam: \_\_\_\_\_ Child's age at this date: \_\_\_\_yrs. \_\_\_\_mos. Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Other tests: \_\_\_\_\_

I have examined the child named on this form and find that he/she IS / IS NOT able to participate in this preschool program. I have examined the immunization record and attest that it is a true and accurate listing.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Immunization Record:

Type	Basic Series				Boosters	
DT	_____	_____	_____	_____	_____	_____
DTaP	_____	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____	_____
DTP/HIB	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
OPV	_____	_____	_____	_____	_____	_____
Tb Tine	_____	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

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**CONSENT and PERMISSION FORMS  
EMERGENCY MEDICAL INFORMATION**

CHILD'S NAME: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Parents can be reached at these numbers while child is in school (include area code):

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

The following people can be called in an emergency and are authorized to transport child to and from school:

Name: \_\_\_\_\_ DL # \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ DL # \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ DL # \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ DL # \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ DL # \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ DL # \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

In the event of accident or serious illness, I (we) request the school to contact me (us) when time allows. If the school is unable to reach me (us), I (we) hereby authorize New Creations Preschool / Parents Day Out to contact the physician indicated on the emergency form and follow his instructions. If the physician is not available, the school is authorized to make whatever arrangements seem necessary.

Name of Hospital: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_

street

\_\_\_\_\_

city

zip code

Phone Number (s): \_\_\_\_\_

**THIS SECTION MUST HAVE  
COMPLETE ADDRESS  
AND TELEPHONE NUMBER  
BEFORE REGISTRATION.**

\_\_\_\_\_  
Father's Signature

\_\_\_\_\_  
Mother's Signature

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