



Required Medical Information

Child: _____ Birthdate: _____

Home Address: _____

Parent: _____ Enrollment Date: _____ Phone: _____

**Immunization Record MUST be attached or faxed to 713-668-3887 before the first day of the school
You must provide proof of Hearing/Vision screening for children age four & older**

Admission Requirement

Physician's Statement: I have examined the above named child within the past year and find that he/she is physically able to participate in the program.

Physician's Written Name Physician's Signature Date

Contact Information:

Physician's Address Physician's Telephone

Parent or Legal Guardian Signature Date

Prior and Continuous Medical Information: *if none, indicate None in space required.

Allergies: _____

Allergy Plan:

Doctor's Signature _____ (Please include a picture of your child to post with Allergy Plan)

Existing Illness:

Previous serious illness or hospitalization in the last 12 months:

Long Term Medication:

General Permission & Release

I give my consent for (child's name) _____ to participate in the following water activities
(Please initial):
_____ Water Table Play _____ Sprinkler play

With the intent to be legally bound, I give permission to St. Thomas' Episcopal Church & School to photograph/videotape my son/daughter (child's name) _____, and use the resulting photograph/videotape for any lawful activities for the purpose of promoting St. Thomas' Episcopal Church & School to the public. I relinquish all rights, title and interest in the finished photographs, negatives and videotape film. Please initial:
_____ Yes _____ No

The following medications are available at the facility. Please initial only the following items that you authorize for your child:
_____sting relief _____ Benadryl® cream _____ children's Motrin® _____ children's allergy relief _____ first aid cream _____ burn gel

In the event that I or my spouse cannot be reached to make arrangements for emergency medical attention,

I authorize the person in charge to secure medical help for my child.

Parent Signature: _____

AUTHORIZED STUDENT PICK-UP

These are the 4 Individuals that are allowed to pick-up _____.
(Student's Name)

Upon arrival, of pick-up, the individual will need to show a form of identification .

Name: _____ Phone Number: _____

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____

**Emergency Contact Information
(other than Parents)**

Name: _____

Address: _____ Phone Number: _____

I certify all information on this form is accurate. **Parent Signature** _____