MESSIAH LAMBS HEALTH RECORD

Phone: (972)398-7560 Fax: (972)398-7598

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 (If a food allergy is listed here a **Food Allergy Action Plan** will also need to be completed): _____

_____

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