SonShine
PRESCHOOL

2024 MEDICAL FORM

Child's Full Name: _____ DOB: _____
Last First Middle *Month/Day/Year*

Child's Physician: _____ Phone: _____

☐ No Known Allergies ☐ Allergies (please explain history and symptoms):

_____

_____

☐ Epi-pen (Allergy Action Plan required)

Diagnosed Food Allergy or Sensitivity: _____

Other Medications (please list): _____

_____

Please list previous/existing illnesses, injuries, disabilities, hospitalizations during the past 12 months or any other information which SonShine Preschool staff should be aware of: _____

_____

_____

Special Care Needs ☐ Yes ☐ No
If yes, please complete the form on **Step 3** of the *Registration + Forms* page.

Authorization for Emergency Medical Attention

In the event I cannot be reached for emergency medical care, I authorize SonShine Preschool to seek emergency medical attention.

Physician: _____

Address: _____ Phone: _____

Emergency Medical Care Facility: _____

Address: _____ Phone: _____

I _____ give my permission and/or consent to SonShine Preschool and its staff to secure & authorize such emergency medical treatment as my child might require while in their care.

Parent Signature: _____

Date: _____

Child's Full Name: _____ **DOB:** _____

I understand that in case of an emergency, SonShine Preschool will use its best efforts to immediately notify me, the parent(s). If I am unavailable, the following persons have my permission to care for my child. **Parent or Legal Guardian Signature:** _____ **Date:** _____

Emergency Contact List (Provide at least one person in the Austin area PLEASE)

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

1. Immunization Record & Hearing and Vision Screening

Each child enrolled or admitted to SonShine Preschool must meet applicable immunization requirements specified by the Texas Department of State Health Services in 25 TAC 97, Subchapter B. **Please check all that are applicable.**

☐ I have attached a copy of my child's most current immunization record.

☐ I have attached an Affidavit for "Exemption from Immunizations for Reasons of Conscience".

☐ I have attached a signed statement from my child's physician indicating a "Delayed Schedule for Immunizations" (Must specify immunization(s) and date of next dosage.)

4- and 5-year-olds:

☐ I have attached a copy of my child's Hearing & Vision Screening Results **OR**

☐ I elect to have the screening completed at SonShine Preschool. Charges will apply.

2. Physician Examination

A physical exam conducted within 12 months of the first day of school is required for admission. This document must be signed and dated by your child's physician. A signed and dated "Statement of Health" satisfies this requirement (see page 3).

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Physician Examination | Statement of Health

I have examined _____ and find that he/she is physically able to participate in the preschool program.

Physician Signature: _____ Date: _____