Spanish@YoungPeoplesWorkshops.com
www.SpanishImmersionPrek.com
www.YPWKids.com

STUDENT HEALTH RECORD 20____-20____ School Year

********Please Note: Physician's signature is required on this form********

Child's Name: ____**Gender:** ________

Date of Birth: __________________ ________
Month/Day/Year **Age**

Child's Doctor:

Name: ____

Address: __________________________________ Phone#: __________________

Allergies: Please list any allergies.

☐ No Known Allergies ☐ Yes Allergies *specify:* ____________________________

☐ Epi-pen, with doctor instructions

Medical Conditions: Please list existing illnesses, previous serious illness/injuries, any medication prescribed for long-term continuous use, and any other information which staff should be aware of: ☐ No Known conditions ☐ Known Conditions, *specify*: ____________

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Immunization Record - ***Please attach current record.***
- an original or a copy of the original from your medical professional.

Vision and Hearing Screening – Mandatory for Age 4 & 5 – *Please attach results.*
- an original or a copy of the original from your medical professional

Physical Examination:
Results and Recommendations by Physician:

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I certify that _____________________________ is in good health and physically able to take part in the school program.

_____________________________ ____________
Child's Physician's Signature **Date**