

HEALTH CARE SUMMARY - Page 1
Divine Savior Lutheran Preschool, Shepherdsville, Kentucky Ph. 502-543-2905

Parent / Guardian Side of Form

Please complete this side of form prior to having Health Care Provider complete reverse side of form.

Name of Child _____ Date of Birth _____

Address _____ Phone _____

Known Food Allergies and Required Diet Modifications: _____

Any other Known Pet Allergies, Medical Allergies, Medical Conditions, or Medical Problems:

Health Insurance Plan: _____

Health Insurance policy number _____

The Hospital of Preference for my child is: _____

(Information used only in case of an emergency in which you could not be reached)

List two people who will assume medical responsibility for your child in the event you cannot be reached.

Name _____

Address _____ Phone (s) _____

Name _____

Address _____ Phone(s) _____

(Optional) I have attached a copy of my medical insurance card

Emergency Treatment Permission

In instances of an emergency situation with my child when I cannot be reached, or when I am delayed in arriving, I give my permission to Divine Savior Lutheran Preschool's staff to act. This includes, in the case of accidental ingestion of a poisonous substance, the use of Syrup of Ipecac if this course of treatment was recommended by the Poison Control Center. I understand that the Paramedics and/or the clinic or hospital selected by emergency care workers will be used if we are unable to reach a parent. I further understand that any costs incurred are my financial responsibility.

Signature of Parent / Guardian: _____

Date: _____

HEALTH CARE SUMMARY - Page 2

Divine Savior Lutheran Preschool, Shepherdsville, Kentucky Ph. 502-543-2905

Health Care Provider Side of Form

Directions: Please complete the following information. This form along with a copy of the child's Immunization Certificate must be returned to Divine Savior Lutheran Preschool, **prior to** the child's preschool attendance.

- I have seen this child approximately : _____ Years _____ Months
(Or check) _____ This is child's first visit (Go to Question #4 if this is first visit).
- I have provided Well Visits for this child, approximately: _____ Yearly _____ Twice Yearly
_____ Not at all Other: _____
- _____ Date of child's last physical exam with you prior to this (if Applicable).
- Please list the status of this child's:
Vision _____
Hearing _____
Speech _____
- Please list any **Food or Medical allergies** known for this child: _____

- Please list any **Diet Modifications** required for this child: _____

- List **Known Health Problems** below. Indicate if you or someone else is following the child for the problem and check which problems require special attention.

<u>Important Health Problems</u>	<u>Followed by You</u>	<u>Followed by Other Med Source (Name)</u>	<u>Requires Special Attention</u>
_____	_____	_____	_____
_____	_____	_____	_____
- Please list any **known conditions which may result in emergency treatment being needed** for this child.:

Other information which may be helpful to our Preschool staff:

Signature of Health Care Provider

Name of Clinic or Health Care Provider

Date

Address of Clinic or Health Care Provider

Thank you for completing this form.

*Please return this form along with an updated copy of this child's **Immunization Certificate** directly or via the parent to:*

Divine Savior Lutheran Preschool, 1025 N. Buckman St., Shepherdsville, KY 40165.
Questions? Call 543-2905 E-mail: preschool@dslc.org

