St. Thomas the Apostle Preschool
MEDICAL Form 2024-2025

PERSONS TO CONTACT IF PARENTS ARE NOT AVAILABLE

1.) NAME: ____________________ RELATION: __________________PHONE: _____________
2.) NAME: ____________________ RELATION: __________________PHONE: _____________
3.) NAME: ____________________ RELATION: __________________PHONE: _____________
4.) NAME: ____________________ RELATION: __________________PHONE: _____________

MEDICAL INFORMATION

FAMILY DOCTOR: _______________________________________PHONE: ___________________
FAMILY DENTIST: ______________________________________ PHONE: ___________________
PREFERRED HOSPITAL: _________________________________ PHONE: ___________________
HEALTH INSURANCE: (CHECK)
PRIVATE/GROUP_____________ MEDICAID ____________ NO HEALTH INSURANCE _________

HEALTH INFORMATION

LIST ANY HEALTH CONDITIONS OR DISABILITIES: _____________________________________
____
LIST ANY MEDICATIONS YOUR CHILD IS ALLERGIC TO: _________________________________
____
OTHER ALLERGIES: ____
____
____
____
MEDICATIONS TAKEN ROUTINELY: ____
MEDICATIONS TAKEN AS NEEDED: ____
ANY VISION/HEARING PROBLEMS? YES/NO (WEARS GLASSES, CONTACTS, HEARING AID)
EXPLAIN: ____
CHILD HAS HAD A PHYSICAL EXAM IN THE LAST TWO YEARS? YES/NO
CHILD HAS HAD A DENTAL EXAM IN THE LAST TWO YEARS? YES/NO

THE SCHOOL IS REQUIRED TO HAVE CURRENT AND COMPLETE IMMUNIZATION RECORD ON EACH CHILD BY THE FIRST DAY OF SCHOOL

The school will never dispense internal medication at the request of a student. **NO ASPIRIN/TYLENOL WILL BE DISPENSED.** In response to parental requests, the school will arrange for the medicine, which is clearly labeled, to be stored and dispensed by a responsible adult. Often this request is a temporary one. If you wish to request on a regular basis, please explain: _________________
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The school will assist students who have minor accidents or ailments, by using ordinary external supplies such as bandages, antiseptic solution, adhesive tape, cold packs, etc. If you **DO NOT** wish any of these supplies used for your child, please explain: ____________
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**Financial assistance is available, for those who qualify, for dental and/or eye care, shoes, and immunizations. If you would like more information on this, please contact the school principal. **

**Vision and hearing screening will be made annually. **

AUTHORIZATION FOR SCHOOL OFFICIALS IN CASE OF EMERGENCY:

I authorize school officials to secure emergency treatment if I cannot be reached. I will assume responsibility for expenses incurred.

DATE: ___________________ PARENT SIGNATURE: ____