St. Thomas the Apostle Preschool
MEDICAL Form 2026-2027

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: _____
_____

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: _____
_____

**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: _____