2022 MEDICAL FORM

SonShine Preschool

Child's Full Name: _____ DOB: _____

Last First Middle Month/Day/Year

Child's Physician: _____ Phone: _____

Address: _____

□ No Known Allergies □ Yes Allergies (please explain history and symptoms): _____

_____

□ Epi-pen (Allergy Action Plan required) Other Medications (please list): _____

Diagnosed Food Allergy or Sensitivity: _____

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

□ No Known Conditions □ Known Conditions (*please specify*): _____

_____

Authorization for Emergency Medical Attention

In the event I cannot be reached for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Phone:
Name of Emergency Medical Care Facility:	Address:	Phone:

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

Signature (Parent or Legal Guardian) DATE

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.

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

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

2022 MEDICAL FORM page 2

SonShine Preschool

Child's Full Name: _____ DOB: _____

1. Immunization Record

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.*

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

If Applicable:

□ 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].

2. Physician Examination

A physical exam conducted within 12 months of the first day of school is required for admission.

I have examined _____ and find that he/she is physically able to participate in the preschool program. (NOTE: A "Statement of Health" from your provider may be submitted so long as it is signed and dated.)

Physician Signature: _____ Date: _____

SonShine Preschool
Austin Ridge Bible Church
9300 Bee Cave Road, Austin, TX 78733, 512-263-1722 FAX: 512-669-7805