

**FIRST KIDS**  
**HEALTH CONSENT FORM - 2020/2021 School Year**  
(Parent to complete this side)

First Presbyterian Church  
P.O. Box 789  
Concord, NC 28025  
704-788-2812 (office)

Date: \_\_\_\_\_  
Class Assignment Age: \_\_\_\_\_

**All forms MUST be mailed or hand delivered to First Kids. Please, do NOT fax this form.**

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_

(Circle name by which child is called) \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Name of Church: \_\_\_\_\_

**Health Report:**

List any operations, medical conditions, broken bones and/or hospital stays (other than birth) that your child has had. \_\_\_\_\_

Frequent Respiratory Infections: Yes/No      Is your child toilet trained? Yes/No

Has your child had the following diseases? Yes/No      Please circle

Measles: Yes/No      German Measles: Yes/No      Scarlet Fever: Yes/No      Whooping Cough: Yes/No

Mumps: Yes/No      Chicken Pox: Yes/No      Poliomyelitis: Yes/No      Heart Disease: Yes/No

Diabetes: Yes/No      Rheumatic Fever: Yes/No      Kidney Disease: Yes/No      Convulsions: Yes/No

Epilepsy: Yes/No      Asthma: Yes/No      Infectious Hepatitis: Yes/No

List any known allergies \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

(First Choice) Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

(Second Choice) Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child receive therapy for any purpose..occupational, speech or language, physical, behavioral etc?

If so, please explain \_\_\_\_\_

Give the name of person to be called in case of emergency when neither parent can be located by phone

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of health insurance company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

Please complete this side and have your child's physician complete the reverse side.  
RETURN THIS FORM AND AN UP-TO-DATE IMMUNIZATION RECORD prior to your child's first day of school.

**FIRST KIDS**  
**HEALTH CONSENT FORM – 2020/2021 School Year**  
 (Physician to complete this side)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_

**Medical History:**

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
HEENT	_____	_____	Heart	_____	_____	Extremities	_____	_____
Skin	_____	_____	Abdomen	_____	_____	Neurological	_____	_____
Lung	_____	_____	Genital	_____	_____	Emotional	_____	_____

Describe any abnormalities: \_\_\_\_\_  
 Does the child have any chronic medical problems and/or take medications for chronic medical problems: Yes/No  
 If Yes, please describe and list medication(s): \_\_\_\_\_  
 Should this child be restricted from any activity? Yes/No If yes, please explain: \_\_\_\_\_

Physician's Comments: \_\_\_\_\_  
 Immunizations are up-to-date. Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please provide an explanation \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Physician's Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date of last examination: \_\_\_\_\_

*First Kids requires that immunizations be up-to-date in accordance with the guidelines of the American Academy of Pediatrics.  
 Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2012*

PLEASE ATTACH A COPY OF THIS CHILD'S IMMUNIZATION RECORD AND RETURN WITH THIS FORM

Vaccine	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs
<b>REQUIRED IMMUNIZATIONS</b>											
Hepatitis B	HepB	Hep B				Hep B					
Varicella						Varicella					
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP				
Haemophilus Influenza type b			Hib	Hib	Hib	Hib					
Pneumococcal			PCV	PCV	PCV	PCV					
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Measles, Mumps, Rubella						MMR					
<b>RECOMMENDED IMMUNIZATIONS</b>											
Influenza		Influenza (recommended yearly)									
Rotavirus			RV	RV	RV						
Hepatitis A						Hep A (2 Doses)					

Examination needs to be within 12 months prior to the first day of school for the 2020/2021 school year.  
 Upon request, an exception for the annual exam may be made for four-year-old children who can show that immunizations are up-to-date.  
 \*American Academy of Pediatrics website: <http://www.aap.org/>