

FIRST KIDS
HEALTH CONSENT FORM - 2021/2022 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.

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 (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
REQUIRED IMMUNIZATIONS											
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					
RECOMMENDED IMMUNIZATIONS											
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 2021/2022 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/>