III Child's health information

Date of child's last physical exam:	Child's health care provider

Blood Group	Genotype	Height (m)	Weight (kg)	Eye defect (yes/no)

Family doctor	Telephone number	Family hospital Street Address

Special health problems? Yes or no? If yes, specify:

Allergies, including drug reactions. Yes or no? If yes, specify:

Regular medications? Yes or no? If yes, specify.

Child Immunization History (Please attach a copy of immunization Card.

Consent to medical care and treatment of minor

I give permission that my child,_____ may be given first aid treatment in the school clinic.

Parent/guardian signature:		Date	Parent/guardian signature :	Date

Other than you, who else has permission to pick up your child from school?

Name (1)	
Relationship	
Address	
Phone number	
Name (2)	
Relationship	
Address	
Phone number	