FIRST METHODIST SCHOOL
403 SOUTH MAIN (MAILING ADDRESS)
DUNCANVILLE, TX 75116
Phone 972-298-5890 Fax 469-533-2372
www.fmsduncanville.com

MEDICAL RECORD FOR:

CHILD'S NAME_____BIRTHDATE_____

HOME ADDRESS_____EXAM DATE_____

LIST OF IMMUNIZATIONS AND TESTS GIVEN:

DTaP/DT1._____2._____3._____4._____5._____Td_____

OPV/IPV (Polio)1._____2._____3._____4._____5._____

HEPATITIS B(HBV)1._____2._____3_____HEPATITIS A (HAV)1._____2._____

M/M/R 1._____2._____ T.B.TEST_____

HIB1._____2._____3._____4._____

PNEUMOCOCCAL (PCV7)1._____2._____3._____4._____

VARICELLA VACCINE1._____2._____OTHER_____

HEALTH INFORMATION:

1. Is this child physically and mentally able to participate in group activities?_____

2. Can this child participate in the program without special care relating to allergies, special diet, restriction of activity, or any other chronic condition?_____

3. Is this child free of contagious disease? _____

4. Does this child have a food allergy? (circle) YES NO. If yes, please complete side 2 of this form. Or any chronic condition?

_____

PHYSICIAN'S SIGNATURE DATE

_____

PHYSICIAN'S ADDRESS PHONE #

403 S. Main Street
Duncanville, TX 75116
972-298-5980 phone
469-533-2372 fax
www.fmsduncanville.com

Allergy and/or Chronic Condition Emergency Action Plan

Student Name: _____

Allergy/Chronic Condition_____

Reaction to Allergen: _____

I, _____ parent/guardian of the above name student, give First Methodist School permission to post my child's health information throughout the school so that all staff are informed of his/her condition.

If my child has a reaction to the above mentioned allergen/chronic condition, the school must _____

_____

_____

_____

_____ _____
PHYSICIAN Signature Parent/Guardian Signature

_____ _____
Date Date

SNACK OPTIONS: (select all that apply)

____ Avoid allergen in school snacks

____ Avoid items produced in facility that contains allergen in school snacks

____ Snack provided by parent