Mary Our Queen Catholic Preschool
2022-2023 Student Health Records

Student_____

Preschool Program: ____ 2-Day AM ____ 3-Day AM ____ 5-Day AM

Mini Mustangs: ____ 2-Day PM ____ 3-Day PM ____ 5-Day PM

Pre-K Program: ____ 5-Day AM ____ 5-Day Full-Day

Please check any of the following health concerns that pertain to your child.

_____ NONE _____Diabetes _____Hearing - specify below

_____Food Allergies - specify below _____Seizures _____Vision - specify below

_____Bee Sting Allergy _____Scoliosis _____ADHD / ADD (circle one)

_____Reactive Airway Disease _____Asthma _____Other - please specify

_____History of wheezing, not diagnosed as asthma (describe below)

If you have checked any of the above, please list symptoms, treatment and modifications that should be made. Use the back of this sheet, if necessary.

_____

_____

_____

Please list any medications your child is currently taking:

Medication_____Reason_____ Daily or As Needed_____Will medication be taken at school? (yes or no)

_____

_____

<u>Prescription and Over the Counter Medications</u>: A Medication Authorization form must be completed, signed and on file in the school office. To dispense prescription medication, the Medication Authorization form requires a health care provider's signature.

Physician and/or specialist_____Phone_____

I understand this information may be shared with school personnel.

Parent Signature_____Date_____