Lamb of God Early Childhood Ministry
Student Health Statement
1401 Cross Timbers Road, Flower Mound, TX 75028
972-539-0055 Fax: 972-539-8194

To be completed by parent:

Child's Name: ________________________________ Sex: ___M ___F Child's Birthdate: ________________

List any allergies:

____

Does the allergy cause a reaction that requires medical attention? ____ No ____ Yes ***If yes, you must complete an Allergy Action Plan and Permission for Medication Form.***

List any recent illness:

____

List any chronic illness/condition:

____

If child has been hospitalized in past 12 months, please describe/explain:

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List any conditions for which child may require special treatment:

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Note: If medications are to be administered during school hours, an ***Allergy Action Plan and Permission for Medication Form*** must be filled out and on file in the school office. All medications **must be** in the original container and labeled for the listed child only.

Child's Physician's Name: _______________________________________

Physician's Address: _______________________________________

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Phone Number(s): _______________________________________

Authorization for Emergency Medical Care

In the event that the child named above requires emergency medical care and parents cannot be reached, I hereby authorize Lamb of God Early Childhood Ministry Preschool to secure such care as may be required at the nearest emergency medical facility.

___________________________________ ________________________

Parent Signature Date