Child's Name ____

SPECIAL SENSES SCREENING RECORD *(By physician/screener)*

Visual acuity and hearing sensitivity screening are required for 4-year olds enrolled in preschool. Rescreening is only required if an abnormality was noted on the first screening. Speech screening is optional (not required.)

HEARING SCREENING:

at 25dB	**R**	**L**
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		

☐ PASS

☐ FAIL—**RESCREEN**

____
Date

____
Physician's signature

VISION SCREENING:

DISTANCE ACUITY: **R-20/**________ **L-20/**________

☐ PASS

☐ FAIL--**RESCREEN**

____
Date

____
Signature

LIMITED ACTIVITIES (List activities in which child should not participate):

____

____

____

____

MEDICATION PRESCRIBED ON A REGULAR BASIS (Must be in original container if administered at facility):

____

____

____

SPECIAL DIET: ____

____

SUGGESTED REFERRALS: ____

____

☐ Doctor's statement: I have examined the above-named child within the past year and find that he/she is physically able to take part in the program.

_______________________________ _______________
Physician's signature (MUST SIGN BOTH SIDES) Date

PINES PRESBYTERIAN PRESCHOOL

12751 KIMBERLEY HOUSTON, TX 77024 713-467-9358

HEALTH RECORD

CHILD'S NAME: ______________________ SEX: M F BIRTHDATE: ______________
First Last Month / Day / Year

ADDRESS: ____
Street City Zip

MOTHER'S NAME: ______________________ TELEPHONE: ____________ ____________
HOME WORK OR CELL

FATHER'S NAME: ______________________ TELEPHONE: ____________ ____________
HOME WORK OR CELL

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the director or person in charge to take my child to:

Name of Licensed Physician	Address	Telephone
Or to (name of hospital or clinic)	Address	Telephone

I give my consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.

____
Signature-- Parent or Legal Guardian Date

IMMUNIZATION RECORD

Month / day / year

IMMUNIZATIONS	1	2	3	4	5	6
DtaP						
IPV						
HIB					Varicella vaccine	
Hep B						
MMR						
Hep A						
Pneumococcus						
TB						
Influenza vaccine						

____
Physician's signature or stamp Date

(See reverse side.)