

HEALTH FORM

If your child has a vision or hearing problem, please describe it:

Serious illnesses, operations, injuries or hospitalizations:

Allergies to drugs and/or foods:

Medications taken on a regular basis:

Disabilities:

Permission for minor medications (i.e.: Panadol) Yes _____ No _____

I hereby certify that the child named above has received the immunization indicated.

I hereby consent to emergency hospital treatment for my child at my expense.

Parent's Signature

Date

Parent's Signature

Date

EMERGENCY MEDICAL AUTHORIZATION

I authorize Fosco International Kindergarten to refer my child, _____, for treatment by a medical professional in the event of an accident or illness at a time when I cannot be reasonably reached, when my home and/ or office number as listed below cannot be reasonably reached, or when it is impracticable to reach me due to the emergency of the situation. I shall bear financial responsibility for any such treatment.

PARENT: _____ (Signature)

PARENT: _____ (Signature)

HOME PHONE: _____

OFFICE PHONE: Father: _____

Mother: _____

EMERGENCY CONTACTS

Should the school be unable to contact us in the event of an emergency, we suggest one of the two people be contacted:

(1) _____
Name in full Phone number

(2) _____
Name in full Phone number

Date

Signature of parent (mother)

Date

Signature of parent (father)