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_____

EXAMINING PHYSICIAN'S NAME_____
(Exam within last 12 months)

PHYSICIAN'S ADDRESS _____

PHYSICIAN PHONE #: _____

We are committed to providing a safe and healthy environment for students, families, and staff.

I hereby release First Methodist School from any liability in the event the child named above contracts a disease or illness at the school.

I understand that **immunization records and medical forms are due to the office no later than the first day of school and my child may not attend school until they are submitted. Vision/hearing screenings (4 years old and up only) are due by the first day of school.** By signing below, I consent to have vision/hearing screenings performed for my child at First Methodist School and billed to my account if vision/hearing results are not submitted by the first day of school.

_____

PARENT SIGNATURE DATE

IMMUNIZATION RECORD ATTACHED: ☐ **HEARING & VISION SCREENING ATTACHED:** ☐

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HEALTH INFORMATION (To be Completed by Physician):

EXAM DATE: _____

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

403 S. Main Street
Duncanville, TX 75116
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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