Providence United Methodist Church Weekday School
2810 Providence Road, Charlotte, NC 28211
Telephone (704)714-9373 Fax (704)365-6800

Medical Record Form

Completion of this form is required. The completed form must be on file in our office before your child may attend class.

Children in need of special care due to disabling or limiting conditions are required to submit care recommendations from their personal physician prior to admission to PUMCWS. Special needs children working with therapists should also submit an *Individual Education Plan* for our files.

Medications and special medical procedures will be administered to a child at the school only by written, dated and signed request of a licensed physician, or by the parent or guardian of the child. Medications must be in the original containers. Parents should authorize the physician at the time of registration to accept any call from Providence United Methodist Church Weekday School for emergency medical care.

I. PERSONAL DATA *(To be completed by parent or guardian)*

Child's Name____
(Last) (First) (Middle)

Child's Birthdate________________________________

Name of Parents or Guardians___________________________Phone (_____)__________________

Address of Parents or Guardians____
(street) (city) (state) (zip)

I give permission for medical information regarding my child to be provided to PUMCWS by my child's physician.

Parent Signature**________________________________** ***Date*****______________________**

II. MEDICAL DATA *(To be completed by physician)*

Immunizations: Enter date of EACH dose – Month/Day/Year

VACCINE	#1	#2	#3	#4
DTP, DtaP				
Polio				
Hib				
Hepatitis B				
MMR				
Measles				
Mumps				
Rubella				
Varicella				

Exemptions from NC State Immunization Law require that a statement must be on file at school in student's permanent record. Exemptions must meet requirements of the law.
_____Medical _____Religious exemption

Weight: __________ Height: _________ Blood pressure: ________ Date of assessment: __________________

List any allergies (if none, please write "NONE")____

List any disabilities, limiting conditions or special needs:________________________________

……………………………………………………………….(child's name) was examined by me on …………………..(date) and is physically able to participate in a preschool program.

Physician's signature**______________________________** ***Date:*** **_____________________**

Physician's address**____** ***Phone #:*****______________________**