ST. DAVID'S EPISCOPAL DAY SCHOOL
2320 Grubb Road
Wilmington, DE 19810-2798
HEALTH RECORD 2022-2023

SECTION A: To be completed by parent/guardian before physical examination.

CHILD'S NAME: _____ DATE OF BIRTH: _____ SEX _____

Check if child has any of the following conditions:

☐ Allergies (foods, medicines, insects, etc.)	☐ Frequent Colds	☐ Vision Difficulty
☐ Asthma	☐ Frequent Ear Infections	☐ Hearing Difficulty
☐ Epilepsy/Seizure Disorder	☐ Frequent Constipation	☐ Speech Difficulty
☐ Physical Handicap	☐ Frequent Diarrhea	☐ Behavioral Issues

OTHER INFORMATION ABOUT YOUR CHILD (serious illnesses/accidents/operations/medications/conditions):

_____

ALLERGY INFORMATION WE NEED TO KNOW ABOUT YOUR CHILD? _____

_____

_____

PARENT/GUARDIAN SIGNATURE **DATE**

SECTION B: To be completed by examining physician/pediatric nurse practitioner
CODE: X – Within Normal Limits
O – See Remarks Below

Scalp		Heart		Vision		Nervous System	
Ears		Lungs		Hearing		Height	
Nose		Abdomen		Blood Pressure		Weight	
Throat,Neck		Genitalia		Teeth			
Eyes		Glands		Extremities			

REMARKS_____

_____

RECOMMENDATIONS_____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP?_____

IMMUNIZATION RECORD:

	Mon/Day/Yr		Mon/Day/Yr		Mon/Day/Yr		Mon/Day/Yr		M/D/Yr
DTP1		**OPV/IPV1**		**MMR**		**Hib1**		**Varicella**	
DTP2		**OPV/IPV2**		**MMR**		**Hib2**			
DTP3		**OPV/IPV3**		**HepB1**		**Hib3**			
DTP/DTaP		**OPV/IPV4**		**HepB2**		**Hib4**			
DTP/DTaP		**Lead Screen**		**HepB3**		**Tine**			

EXAMINER'S SIGNATURE_____ **MD/PNP DATE:** _____

PRINTED NAME: _____ TELEPHONE: _____

ADDRESS: _____

Over - >

ST. DAVID'S EPISCOPAL DAY SCHOOL
ESTABLISHED 1955

CHILD INFORMATION FORM

To be completed in full by parent/guardian:

Child's Full Name: _____ Nickname: _____

Names of Parent(s)/Guardians: _____

Address: _____

Email Address(es): _____

In case of illness or accident during school hours, we may contact you at:

Home Phone(s): _____

Work Phone(s): _____

Cellphone(s):_____

If parent/guardian is not available, we may contact (please list local contacts):

1. _____
Name Telephone(s) Relationship to Child

2. _____
Name Telephone(s) Relationship to Child

Doctor's Name _____
Phone

Dentist's Name _____
Phone

Health Insurance Identification Information:

Policy Holder _____ Policy No. _____

Company _____ Group No. _____ Phone No. _____

PARENT/GUARDIAN MUST SIGN EMERGENCY MEDICAL PERMISSION BELOW:

I give St. David's Episcopal Day School permission to administer emergency first aid to my child and in case that my child's doctor or I cannot be reached, and accompany my child to the nearest hospital emergency room, if necessary. I understand I will be financially responsible for the cost of such treatment.

_____
Signature Parent/Guardian Date

2320 Grubb Road Wilmington, DE 19810
(302) 475-3747 stdavidskidsde@outlook.com