

# Covenant Community School ~ Preschool @ First ARP Gastonia

## HEALTH CERTIFICATE

Section I to be completed by parent/legal guardian:

CHILD \_\_\_\_\_  

Last
First
Middle
Nickname

Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PARENT/LEGAL GUARDIAN \_\_\_\_\_  

Last
First

Address \_\_\_\_\_  

Street
City
State
ZIP

1. Does your child have any medical conditions the staff should be made aware of? \_\_\_\_\_
2. Does your child have any known allergies? \_\_\_\_\_
3. Is your child on any special dietary restrictions? \_\_\_\_\_
4. Do you have any special requests regarding your child's care while at school? \_\_\_\_\_  
 Please read health plan requirements on back.

\_\_\_\_\_  
parent / legal guardian signature

Section II to be completed by child's physician:

1. Does this child enjoy good health free from any chronic conditions? \_\_\_\_\_
2. Has this child demonstrated normal motor and mental development? \_\_\_\_\_
3. Should this child be on any physical or dietary restrictions? \_\_\_\_\_
4. Are the child's immunizations up to date? \_\_\_\_\_
5. What was the result of the child's most recent tuberculin skin test? \_\_\_\_\_ Date of test \_\_\_\_/\_\_\_\_/\_\_\_\_
6. Date of most recent health checkup? \_\_\_\_/\_\_\_\_/\_\_\_\_
7. Any comments or recommendations? \_\_\_\_\_  
 Please read health plan requirements on back.

HISTORY OF IMMUNIZATIONS - Please add dates received- Shaded area indicates ages due

Age	HepB	DTaP	Hib	IPV	PCV7	MMR	Var
Birth							
2 months							
4 months							
6 months							
12 months							
15 months							
4-6 years							

Results of Tuberculin Test, if given: Type \_\_\_\_\_ Date \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

If child has not had an immunization, please note the reason- parental \_\_\_\_\_ religious \_\_\_\_\_ other \_\_\_\_\_.

I certify that the above named child received the listed vaccine doses on the date(s) specified.

\_\_\_\_\_  
Physician signature

## INDIVIDUALIZED CARE PLAN

For each child with special health care needs or food allergies or special nutrition needs, the child's health provider gives the program an individualized care plan that is prepared in consultation with family members and specialists involved in the child's care. The program protects children with food allergies from contact with the problem food. The program asks families of a child with food allergies to give consent for posting information about that child's food allergy and, if consent is given, then posts that information in the food preparation area and in the areas of the facility the child uses so it is a visual reminder to all those who interact with the child during the program day.

Individualized Care Plan is due before the first day of school.

I give consent to post information about my child's food allergy in the food preparation area and in the areas of the facility the child uses.

Childs' name \_\_\_\_\_

\_\_\_\_\_  
Parent's signature

Need a Vaccination?

All vaccinations are available at the Gaston County Health Dept. Call 704-853-5000 for more information.