

Please Print Only

All sections of this form must be completed and returned along with your child's enrollment application.

Child's Full Name: _____ Date of Birth: _____ Sex: M F

Mother's Name: _____ Father's Name: _____

this section must be completed by the child's personal physician.

immunization status physical examination:

Height: _____	Weight: _____	BP: _____ / _____
Posture: _____	Hair: _____	Skin: _____
Ears: _____	Nose: _____	Throat: _____
Gums: _____	Tongue: _____	Neck: _____
Abdomen: _____	Reflexes: _____	Deformities: _____
Lungs: _____	Heart: _____	Genitals _____

medical history

Immunizations	1 st	2 nd	3 rd	1st Booster	2 nd Booster
D.P.T.					
Polio					
M.M.R.					
HIB Vaccine					
B.C.G					
DTap					
Hepatitis B					
Varicella					
Covid19 Vaccine					

	Yes	No		Yes	No		Yes	No
Seizures Tonsillitis			Sickle Cell			Asthma		
Skin Problems			Fainting Spells			Hepatitis		
Diabetes AD/HD			Pneumonia			Tuberculosis		
Hearing Problems			Chicken Pox			Worms		
Vision Problems			H.I.V /A.I.D.S			Cancer		
			Leukemia			Meningitis		
			Heart Problems					

Is the child allergic to any thing or any medications? Yes No

If yes, please indicate the items to which the child is allergic:

The child's general health status can be described as: Excellent Good Poor

Is this child physically fit for physical education classes? Yes No

Please list any physical education restrictions the child may have:

Is the child under special medical care? Yes No

If yes, please share the details of the care being administered:

Please list any surgeries and approximate medications the child is currently on:

Is the child experiencing any developmental delays/learning differences that the school should be aware of?

Yes No If yes, please state below: _____

Is the child Autistic? Yes No

Physician's Signature: _____

Physician's Additional Comments:

Physician's Office Stamp Here:

this section must be completed by the child's parent /guardian

How is your child's behavior best described?

Socially well-adjusted shy or withdrawn fights/hits/bites

Does your child have any emotional issues that the school should be aware of? Yes No

If yes, please explain:

insurance information

Is your child covered by health insurance: Yes No

If yes, please provide the name of insurance company:

Group Insurance No. _____ Individual Insurance No. _____

The name of the child's Primary Care Physician _____

in case of an emergency

Please provide a minimum of (3) three Emergency Contacts (other than the child's parents):
Please list the contacts with the most desired to the top and the others falling beneath it.

First Name: _____ Last Name: _____

Relationship to child: _____

Please list a minimum of (2) contact numbers for this individual:

1) _____ 2) _____

First Name: _____ Last Name: _____

Relationship to child: _____

Please list a minimum of (2) contact numbers for this individual:

1) _____ 2) _____

First Name: _____ Last Name: _____

Relationship to child: _____

Please list a minimum of (2) contact numbers for this individual:

1) _____ 2) _____

In the event of an emergency where hospital care is deemed necessary and where I cannot be reached, Bluebrook hereby receives my consent to have my child taken to:

Doctor's Hospital Princess Margaret Hospital

and to provide any emergency care deemed necessary for my child. I further authorize the transfer of my child's health records to the hospital indicated above.

In the event of an emergency requiring first aid to be administered to save my child's life, I authorize the CPR certified staff of Bluebrook to conduct first aid procedure/s deemed necessary for my child until such time as a paramedic arrives or my child arrives to hospital.

Does your family have religious restrictions as it pertains to medical care? Yes No

If yes, please provide details:

Signing Parent/Guardian's Full Name: _____

Parent's Signature: _____ Date _____

Please return this copy both completed and signed to Bluebrook's Administration Office along with other enrollment requirements.

thank you!