

## HEALTH DOCUMENTATION REQUIREMENTS

**CHILD'S NAME:** \_\_\_\_\_

**IMMUNIZATION RECORDS REQUIREMENT:** Immunization records and varicella verification must be presented when your child is admitted to Waco Montessori School or within one week of admission. Please complete the following:

**Immunization records attached:**  Yes  No - If No, an "Exemption from Immunizations for Reasons of Conscience" form must be attached.

**Varicella verification:** Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) \_\_\_\_\_ and does not need varicella vaccine.

\_\_\_\_\_  
Signature - Parent or Legal Guardian

\_\_\_\_\_  
Date

**HEALTH STATEMENT REQUIREMENT:** One of the following must be presented when your child is admitted to the Toddler/Early Childhood Program or within one week of admission. Check to indicate the option you select:

**OPTION 1**

**HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past 12 months and find that he / she is physically able to take part in the day care program.

\_\_\_\_\_  
Health Care Professional's Signature

\_\_\_\_\_  
Date

**OPTION 2**

Within 12 months of admission, I will obtain a health care professional's statement and will submit it to the day care facility.

**OR**

My child has an appointment for a physical examination:

\_\_\_\_\_  
Name and address of Health Care Professional

\_\_\_\_\_  
Date

I will submit the statement, from a health care professional to the child-care facility following the examination

\_\_\_\_\_  
Signature - Parent or Legal Guardian

\_\_\_\_\_  
Date

In case of emergency, Waco Montessori School procedure will be to contact the parent at home or work. If unable to reach either parent, we will contact the next emergency contact listed.

I will not hold the school financially responsible for any emergency care or transportation of said child.

I hereby authorize Waco Montessori School, its administrators, teachers, staff, parents and/or volunteers to obtain any necessary or appropriate medical care and treatment for my child, and authorize such persons to make any decisions required for medical treatment. I authorize any health care provider to treat my child and acknowledge full financial responsibility for all costs incurred.

\_\_\_\_\_  
Signature - Parent or Legal Guardian

\_\_\_\_\_  
Date

Insurance Company Provider: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Subscriber Number: \_\_\_\_\_

Group or Network Number: \_\_\_\_\_

Physician Name and Phone Number: \_\_\_\_\_

We do not carry health insurance.

We do not wish to provide this information.