WESTMINSTER

City of Westminster Preschool Program

Child's Health Statement

All licensed child care facilities must obtain a signed and dated statement of the child's current health status. This report is to be filled out by a licensed physician or other health care professional who has seen the child in the past twelve months.

**Due prior to the first day of Preschool. Your child may not attend City of Westminster Preschool until this form is signed by a physician and received via ePACT.*

Child's Name: _____ Sex: _____

Child's Phone Number: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian: _____ Parent/Guardian: _____

Please check any illnesses the child has had and give approximate dates:

☐ Asthma: _____ ☐ Diabetes: _____

☐ Epilepsy/Seizures: _____ ☐ Severe Allergies: _____

☐ Other: _____

Surgery / Accidents / Illnesses / Chronic Health Problems: _____

_____

Describe any physical condition requiring the facility's special attention: _____

_____

Behavioral issues and diagnosis: _____

Comments: _____

Has your child received any of the following screenings in the last year? (Please circle): Hearing Vision Dental

Any results that may be of concern? _____

Allergies: _____

Medication(s) prescribed: _____

**If your child needs medication during school hours, please submit a medication/allergy/asthma authorization form in ePACT prior to your child's first day of school.*

**If your child does not need medication at school but you have noted medication on this form, please also submit the form for refusal to provide medication.*

Are immunizations up to date? Yes No *(This program has the right to accept unimmunized children.)*

Please record immunizations and dates administered on the **Colorado Department of Health Certificate of Immunization** and upload to ePACT.

**Not all forms are state approved - please look for the state approved seal on the form before submitting.*

Date of most recent examination of child: _____ Date of next scheduled exam: _____

Name of Licensed Physician/Health Care Professional: *(please print)* _____

Address: _____ City: _____ Zip: _____ Phone: _____

This child is in satisfactory health and apparently free from any communicable disease. I find no reason for this child not to take part in the preschool/camp program and activities except as listed above.

_____ Date: _____

Signature of licensed physician or other healthcare professional