The Grammar School
69 Hickory Ridge Road S., Putney, Vermont 05346

PRESCHOOL FAMILY INFORMATION AND RELEASE FORM

2017-18 ***If you have another child in a grade other than preschool please fill out a K-8 information form as well, Thank you.***

Student #1_____**Birthdate**_____**Preschool 2017/18**
Last First Middle

Student #2_____**Birthdate**_____ **Grade**_____
Last First Middle

Student #3_____**Birthdate**_____ **Grade**_____
Last First Middle

Parent/Guardian #1_____**Home Phone**_____

Address_____
Street Town State zip

Cell_____**Email**_____

Occupation_____**Company Name**_____**Work #**_____

Parent/Guardian #2_____**Home Phone**_____

Address_____
(If Different from Parent #1) Street Town State Zip

Cell_____**Email**_____

Occupation_____**Company Name**_____**Work #**_____

EMERGENCY CONTACTS IF NIETHER PARENT CAN BE REACHED (must have 2)
Name:_____**Phone**_____**Phone#2**_____

Address:_____**Relationship**_____

Name:_____**Phone**_____**Phone#2**_____

Address:_____**Relationship**_____

CHILD PICK UP
The following people have my permission to pick up my child from school
Name:_____**Phone**_____**Phone #2**_____

Name:_____**Phone**_____**Phone #2**_____

Signed_____ **Date**_____

Please always remember to sign your child in at drop off and out at pickup every day! Thank you!

FIELD TRIP RELEASE

_____**Has/Have my permission to go on any school sponsored trips.**
Child/Children's name/s

In the event of a school bus breakdown:_____**Has/Have my permission to ride to and from school with a TGS parent or Staff member.**
Child/Children's name/s

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802-387-5364 fax 802-387-4744

Pre-K Student Health Report 2017-2018

(To be completed by student's health care provider)

Student's name:_____ Date of Birth:_____ Sex: M F

ALL NEWLY ENROLLED students must have a complete physical examination prior to the start of school in September. Realizing that a yearly physical is not always necessary for every child, **returning students** are not required to have a yearly physical. If this is the case for this patient, would you please sign and return this form based on information from the last physical and note any significant changes in the student's health status since that physical.

I hereby certify that I have performed a complete physical examination of the student named above on _____ (date of last physical).

MEDICAL PROBLEMS/CONDITIONS: (please explain)

Asthma: ___ Yes ___ No Emergency Medications: _____

Diabetes: ___ Yes ___ No Emergency Medications: _____

Seizure Disorder: ___ Yes ___ No Emergency Medications: _____

OTHER/Comments:

IMMUNIZATIONS: COMPLETE THE FORM ON REVERSE OR ATTACH A COMPLETE IMMUNIZATION HISTORY

ALLERGIES: (please explain) **EpiPen Required: ___ Yes ___ No**

SCREENING: (date of screening exam _____)

Visual _____ Hearing _____

MEDICAL ACCOMMODATIONS NEEDED FOR SCHOOL OR ADDITIONAL HEALTH INFORMATION:

PHYSICAL EDUCATION / PLAYGROUND & SCHOOL ACTIVITIES QUALIFICATION

____ **Physically qualified for all physical education, playground & school activities**

____ Restrictions: _____

_____ _____

Health Care Provider's signature **Date**

Health Care Provider's name: _____ Phone: _____

Please return this form to The Grammar School by September 1, 2017. Thank you

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REQUIRED IMMUNIZATIONS Pre-K

Healthcare Provider Signature Required

Student Name _____ **Date of Birth** _____/_____/_____
month day year

REQUIRED IMMUNIZATIONS

All numbered areas are required to be completed by a healthcare provider AND comply with ACIP guidelines.
All immunizations must be recorded on this form in a format that includes the month/day/year.

IMMUNIZATION	DATE ADMINISTERED (month/day/year)				
Diptheria, Tetanus, Pertussis (DTP, DTaP)	**1**	**2**	**3**	**4**	
Polio (IPV or OPV)	**1**	**2**	**3**		
Hib	**1**	**2**	3	4	
PCV	**1**	**2**	**3**	4	
Measles/Mumps/Rubella Combination Vaccine	**1**				
Hepatitis B	**1**	**2**	**3**		
Varicella (Chicken Pox) OR documentation of history of disease	**1**		History of disease at age _____ years* *(Complete Documentation of Disease Form)		

OTHER IMMUNIZATIONS

IMMUNIZATION	DATE ADMINISTERED (month/day/year)				

SIGNATURE of HEALTH CARE PROVIDER

I have reviewed the past medical history and the immunization record of this individual and have determined both to be accurate and complete.

Health Care Provider Name _____ **Signature**_____

Phone _____ Fax _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Please return this form to The Grammar School by September 1, 2017. Thank you