FAITH • FAMILY • EXCELLENCE
MAGNUSON
CHRISTIAN SCHOOL

HEALTH CARE SUMMARY FORM

This form is required for all incoming kindergarten students and all students with allergies or significant health changes since last year.

Child's Name _____ Date of Birth _____ Grade_____
Last First Middle

Home Address _____
Street City State Zip Code

Parent/Guardian(s) name _____

Home Phone _____

Date of last physical examination _____

Does your child have any allergies – including allergies to meds? _____

If yes, what? _____

Is a modified diet necessary? _____

Is any condition present that would result in an emergency? _____

If yes, what? _____

What is the status of this child's:

Vision _____

Hearing _____

Speech _____

Does your child take any medications on a regular basis? _____ If yes, please list below and please fill out an Authorization for Administration of Medication form *IF* it will need to be administered at school.

Medication	Dosage/How Often	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Magnuson Christian School admits students of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies, admissions policies, scholarship and loan programs, and athletic and other school-administered programs. Each student is considered part of the total Christian school community and is expected to participate in all classes and activities.

List below important health problems or information and indicate if your child follows up with a regular doctor.

Important Health problems	Follow up with Doctor	Followed by med source (Clinic Name)	Requires special attention by MCS?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other information that would be helpful to Magnuson Christian School

_____

_____

_____

_____

_____

Name of Primary Physician or Clinic and address _____

_____

Signature of parent/guardian: _____ Date _____

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