Health Certificate
Presbyterian Weekday School,
First Presbyterian Church
1621 East Garrison Boulevard, Gastonia NC 28054,
Telephone 704-864-2651

This form must be in the student's folder prior to the first day of school. Please schedule an exam or take to doctor for completion. It is a NC state policy to have this information in place for the health and safety of all our children.

Section I to be completed by parent/legal guardian:

Child's Name: _____
Last First Middle Preferred Name/Nickname

Age: _____ Birth Date: ____/____/_____ Gender: F M

Parent/Legal Guardian(s): _____

1. Does your child have any medical conditions the staff PWS should be made aware of? _____
2. Does your child have any known allergies? Yes No If Yes, what type of allergies? _____
_____ Please give details on the **Individual Care Plan** form
3. Does your child have any known food allergies? Yes No If yes, what type of food allergies? _____

_____

If your child has food allergies that require an EpiPen, please complete the **Food Allergy and Anaphylaxis Emergency Care Plan** form. This form will be displayed in the area where food is served and consumed.

4. Do you have any special requests regarding your child's care while at PWS_____

_____

I certify that all the above information is true to the best of my knowledge. _____
Parent / Legal Guardian Signature

Section II to be completed by child's physician:

1. Does this child enjoy good health, free from any chronic conditions? _____
2. Has this child demonstrated normal motor and mental development? _____
3. Should this child be on any physical or dietary restrictions? _____
4. Are the child's immunizations up to date? _____
5. What was the result of the child's most recent tuberculin skin test? _____ Date of test ___/___/___
6. Date of most recent health checkup _____/_____/_____
7. Any comments, recommendations or concerns? _____

History of Immunizations: Fill in Dates of Immunizations or attach a print out from doctor's office

Age	HepB	DTaP	Hib	IPV	PCV7	MMR	Var
Birth							
2 months							
4 months							
6 months							
12 months							
15 months							
4-6 years							

If the child has not had an immunization, please note the reason: medical_____ other_____

I certify that the above-named child received the listed vaccine doses on the date(s) specified in this chart or on the attached print out from the physician's office.

_____ _____
Physician signature **Date**