St. Luke's United Methodist Church
After-School Care / Summer Kids' Kamp
MEDICAL INFORMATION

ASC/KK Fax: 713-961-7216

This form is to be completed and signed by a physician:

Child's Name_____Birth Date_____Gender_____

Doctor's Name_____Phone_____

Doctor's Address_____
Street Suite Zip

Immunizations	Date 1st Dose	Date 2nd Dose	Date 3rd Dose	Date 1st Booster	Date 2nd Booster
DTP					
Polio					
HibCV					
Hepatitis B				Doctor's Verification must be submitted:	
MMR				Measles Date of Illness:	
Measles				Mumps Date of Illness:	
Varicella				Chicken Pox Date of Illness:	
TB Skin Test	Date Given:		Date Read:	Result:	
TB Skin Test					

Please check any of the following special problems this child may have / have had:

_____allergies
_____existing illness
_____previous serious illness
_____injuries during the past 12 months
_____medication prescribed for long-term use
_____other info which school staff should be aware of

If any of the above are checked, please explain:

_____

_____

_____

_____

I have found that _____ is physically able to participate in group activities.

Physician's Signature_____Date_____