

**Lamb of God Early Childhood Ministry  
Student Health Statement**

1401 Cross Timbers Road, Flower Mound, TX 75028  
972-539-0055 Fax: 972-539-8194

**To be completed by parent:**

Child's Name: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F Child's birth date: \_\_\_\_\_

List any recent illness: \_\_\_\_\_

List any chronic illness/condition: \_\_\_\_\_

List any allergies: \_\_\_\_\_

If child has been hospitalized in past 12 months, please describe/explain: \_\_\_\_\_

\_\_\_\_\_

List any conditions for which child may require special treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Note: If medications are to be administered during school hours, a Permission for Medication Form must be filled out and on file in the school office. All medications **must be** in the original container and labeled for the listed child only.

**Authorization for Emergency Medical Care**

In the event that the child named above requires emergency medical care and parents cannot be reached, I (we) hereby authorize Lamb of God Early Childhood Ministry to secure such care as may be required at \_\_\_\_\_ or nearest emergency medical facility.

Child's Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number(s): \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date