St. Peter's ECDC Student Medical Form **2026-2027**

20775 Kingsland Blvd Katy, TX 77450
P: 281-492-0623
F: 888-311-5875

Child's Name _____ DOB _____/_____/_____ Age as of 9/ 1 /2026 _____

Address _____ Main Phone (_____) _____

Physician's Name _____ Physician's Phone (_____) _____

Physician's Address _____

For Physicians, please provide the following items listed below:

_____ **Copy of all immunizations**.

- If the child is on a catch-up schedule due to ***medical reasons***, please provide a signed and dated copy of the catch-up schedule. *This must be received before the 1st day of school.*
- St. Peter's ECDC accepts **Immunizations Exemption Affidavits** for documented medical reasons and reasons of conscious. All children must show proof of current immunizations prior to the first day of school.

_____ **Allergy Action Plan** is required if the child has any allergies and has a prescribed Auvi-Q or EpiPen. The **Allergy Action Plan and medication** *must be received before the 1st day of school.*

- **Does the child have any known Allergies?** **Yes _____** **No _____**
- **If yes, does the child require a prescribed Auvi-Q or EpiPen?** **Yes _____** **No _____**
- **Has the child had an anaphylactic shock previously?** **Yes _____** **No _____**

_____ **Copy of full Hearing and Vision test results for all 4- and 5-year-old students in addition to this completed form.**

- **Hearing Screening:** **Date _____/_____/_____** **Passed _____** **Failed _____**
- **Vision Screening:** **Date _____/_____/_____** **Passed _____** **Failed _____**

_____ **Other Special Care Plan** is required if the child has a diagnosed skin condition, eczema or asthma and has prescribed medication to help with flare ups. A Special Care Plan and medication *must be received before 1st day of school.* Write NONE if the child has no other known special care needs or concerns.

Physician's Statement: I have examined the above child within the past year and find that he/she is physically able to take part in the ECDC preschool program.

_____

Physician's Signature **Date**