THE PEACOCK'S PLUME

1094 Bloomingdale Avenue Fl 33596 (813) 684-0700 Fax: 684-0766

AUTHORIZATION FOR MEDICAL TREATMENT

TO WHOM IT MAY CONCERN:

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child, _____, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants. I agree to pay all medical and ambulatory expenses.

Name of child's physician_____ Telephone_____

Allergies of child_____

Date of Last DTP or Tetnus_____

Name of Insurance Company (Medical) _____

Policy Number_____ Expiration Date_____

Auto Insurance Company_____

Policy Number_____ Expiration Date_____

EMERGENCY PHONE NUMBERS

Father at Work _____ Ext. _____ At Home _____ Cell _____

Mother at Work _____ Ext. _____ At Home _____ Cell _____

Father's place of employment _____

Mother's place of employment _____

Other _____ Ext. _____ At Home _____ Cell _____

If, in the opinion of a properly licensed and practicing physician, my child needs medical or surgical services which require my consent before being supplied, and I cannot be reached, I hereby authorize, appoint, and empower the Administrator, or his designee, to furnish on my behalf such written or oral authorization as may be so required. Further, I release the Administrator, or his designee, and The Peacock's Plume Company from any liability which might arise from the giving of such authorization, it being my desire that my child be furnished with such medical or surgical services as soon as reasonably possible after the need arises.

_____
Parent's/Guardian's Signature

NOTARIZATION REQUIRED (available at The Peacock's Plume)
State of Florida – County of Hillsborough
Witness my hand and official seal, this _____ day of _____, A.D. 20_____.
My commission expires _____.

_____
Notary Public – State of Florida at Large

THE PEACOCK'S PLUME COMPANY
CHILD HEALTH ASSESSMENT 2017-2018

Name: _____

Birth date _____ Class enrolled _____

1. Check if student has had any of the following. Give dates of any positive answers.

____ Polio ____ Jaundice ____ Whooping Cough ____ German Measles
____ Fractures ____ Mumps ____ Tuberculosis ____ Rheumatic Fever
____ Measles ____ Malaria ____ Chicken Pox ____ Scarlet Fever
____ Kidney Infection ____ Concussion/Head Injury
____ Other

Explanations_____
_____

2. Check if student has any of the following. Please explain any positive answers.

____ Asthma ____ Abdominal Pain ____ Hay Fever ____ Constipation
____ Ear Trouble ____ Hearing loss/defect ____ Bladder problem ____ Contact lenses
____ Epilepsy ____ Heart Trouble ____ Tonsillitis ____ Indigestion
____ Diabetes ____ Hernia ____ Glasses

Explanations _____
_____

3. Is the student on any medication: ____ Yes ____ No
Specify _____

4. Does your child have any physical limitations which might require some adjustment to a normal student activity schedule? ____ Yes ____ No
If yes, please describe _____

5. Has your child had any operations? ____ Yes ____ No
If yes, please describe _____

6. Does your child have any allergies? ____ Yes ____ No
If yes, please describe _____

7. Has your child ever been treated for any nervous, mental or emotional disorder? ____ Yes ____ No
If yes, when and how long a period _____

8. Is there any other medical information that you feel we should have about your child?
_____