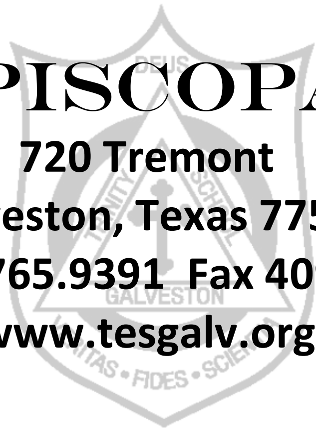
TRINITY EPISCOPAL SCHOOL



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PHYSICIAN RELEASE FORM & IMMUNIZATION REQUEST

Student Name ____

Does the child have any allergies to drugs? If so, explain
____
____
____

Does the child have any other significant allergies (i.e. food)? If so, explain
____
____
____

List all medications taken regularly?
Why?____
____
____
____

Are there any limitations to this child's activities? _______________________________
____
____

This child is current with all required immunizations.

This child has been examined by me on _______/_______/_______ and found to be free of all contagious and transmittable diseases and is physically able, with the exceptions noted, to participate in the school program.

___ I have attached a copy of the updated immunization record for this child.

Physician's Signature_________________________________ **Date**______________________