

**The Children's School of Boise, Inc.,**  
**1015 N. 8<sup>th</sup> St., Boise, ID 83702,**  
**208-343-6840, fax # 208-429-8153**  
**Health Records**

**Child's Name** \_\_\_\_\_ **Birthdate** \_\_\_/\_\_\_/\_\_\_

**Parent signature authorizes physician to release health information requested on  
this form to The Children's School** \_\_\_\_\_

**Parent signature required**

Date of most recent health exam: \_\_\_\_\_

Results of most recent health exam including recommended follow-up: \_\_\_\_\_

**Special health needs** (e.g., , allergies, asthma, chronic illness, hearing /vision impairment, diabetes, etc.)

Daily or Weekly Medication for special health needs?

- Yes
- No

Physician instructions for treatment of special health needs. Please be specific and detailed regarding treatments and medication administration.

**\*\*Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**\*Physician Signature required**

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**\*\* This form must be signed by a physician even if there are no special needs/instructions**

- Current immunization records have been provided to the school.
- Current immunization exemptions signed and provided to the school, if applicable, with TCS paperwork regarding exemptions completed.