

ST. JOHN'S PREPARATORY SCHOOL



Shaw Park Road, Ocho Rios, St. Ann

Telephone: 974 2581

E-mail: stjohnsprep2@yahoo.com

SCHOOL MEDICAL CERTIFICATE

Name: _____ (M / F) Age: _____ Date of Birth: _____

Address: _____ Telephone: _____

PAST MEDICAL CONDITION	YES	NO	PRESENT MEDICAL CONDITION	MEDICATION
Allergies			1.	
Asthma			2.	
Epilepsy			3.	
Eye Problems				
Ear Problems				
Heart Condition				
Rheumatic Fever				
Deformities				
Other				

IMMUNIZATION STATUS:

Adequately immunized for entry to school: Yes ___ No ___

Additional Boosters of New Vaccines advised: Yes ___ No ___

THIS IS TO CERTIFY THAT _____ HAS BEEN EXAMINED FOUND TO BE OF
_____ PHYSICAL AND MENTAL HEALTH TO ATTEND SCHOOL AND FIT FOR ALL NORMAL ACTIVITIES.

SIGNATURE OF PHYSICIAN: _____

DATE: _____

DOCTOR'S SEAL:

SAFETY (Form C)

NAME OF CHILD: _____

ADDRESS: _____

NAME OF PARENT: _____

TELEPHONE: _____ (Home) _____ (Business)

How does your child travel to and from school? Please tick:

- private car _____
- taxi _____
- bus _____
- walking _____

Who picks up your child after dismissal? Name: _____

Address: _____

Telephone Number: _____

What is the type and license number of the vehicle? _____

If the person is unable to pick up your child on any afternoon what arrangements have you made?

**I agree that it is my responsibility to pick up my child by 3:30 p.m. every day. You can make arrangement with a teacher for after care services if you so desire.
The school indemnifies itself against any accident or damages to the child, after 3.30 p.m. unless the child is participating in a required activity.**

Signature of Parent / Guardian

Date