



MEDICAL INFORMATION FORM

Instructions: Date of last well check, physician's signature and updated immunization record are required. Insurance information and parent's signature are required under "Parent Authorization for Emergency Medical Treatment."

Child's Name _____ DOB _____ Gender Male Female

Doctor's Name _____ Doctor's Phone _____

Doctor's Address _____
Street Suite Zip

Please check any of the following special problems this child may have/have had:

- allergies* injuries during the past 12 months
- existing illness medication prescribed for long-term use
- previous serious illness hospitalizations during past 12 months
- other info of which the school staff should be aware *please request a Food Allergy Action Plan form, if applicable

If any of the above are checked, please explain: _____

I have examined the above named child on _____ (**date of last well check**) and found that he/she is physically able to take part in the St. Luke's Day School program.

Physician's Signature **Date**

PARENT AUTHORIZATION for EMERGENCY MEDICAL TREATMENT

Child's Name _____

Health Insurance Provider: _____

Group # _____ ID # _____

In the event I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to the recommended hospital or to his/her doctor.
I give my consent for necessary emergency treatment.

Parent's Signature: _____