St. Luke's DAY SCHOOL
PLAYING & LEARNING TOGETHER

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*
- ☐ existing illness
- ☐ previous serious illness
- ☐ other info of which the school staff should be aware
- ☐ injuries during the past 12 months
- ☐ medication prescribed for long-term use
- ☐ hospitalizations during past 12 months

*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: _____

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