

SCHICK'S CROSSING PRESCHOOL

MEDICAL FORM

Child's Name: _____

Child's Doctor: _____ Phone: _____

Hospital Affiliation: _____

Medical History

1. Is your child under routine (well-child) medical care? Yes No

2. Is your child taking any medication? Yes No

If Yes, please list type and reason: _____

3. Does your child have any allergies? Yes No

If Yes, please list: _____

4. Does your child have any medical/physical problems? Yes No

If Yes, please explain: _____

5. Does your child have any vision, hearing or speech problems? Yes No

If Yes, please explain: _____

6. Has child had any significant injuries or illnesses in the past year? Yes No

If Yes, please explain: _____

7. In case of a medical emergency, who should we contact if parents cannot be reached?

1st : _____ Phone: _____

2nd : _____ Phone: _____

Every student must have a completed DHS Physical Examination form on file by the first day of school.

As parent/guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor for the aforementioned minor in the event of a medical emergency. I also authorize qualified preschool staff to administer CPR and/or First Aid if necessary for the health and safety of my child.

Parent/Guardian Signature

Date