

Medical Information

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| Child’s Name |  |

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| Pediatrician Name |  |
| Pediatrician Phone Number |  |
| Please list child’s allergies: |  |
| Does your child require emergency rescue medication for their allergies? |  |
| *If yes, additional Medication Forms will be provided by the Preschool Office.* |
| Please list any daily medications: |  |
| Emergency Medical Contact #1 |  |
| Emergency Medical Contact #2 |  |
| Hospital Preference |  |

Parent Signature: Date: