

ST. TIMOTHY LUTHERAN CHURCH PRESCHOOL  
MEDICAL INFORMATION FORM

\_\_\_\_\_  
Name of child

\_\_\_\_\_  
Child's date of birth

\_\_\_\_\_  
Mother's Name

\_\_\_\_\_  
Father's Name

\_\_\_\_\_  
Best number to call during school in case of an emergency

\_\_\_\_\_  
Pediatrician's Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Hospital Preference

Does your child receive annual physicals from a pediatrician?      Yes      No

Is your child up-to-date with their vaccination schedule?      Yes      No

**Please submit a copy of your child's recent immunization record with this medical form. If you do not have a copy, please ask your pediatrician's office for one. Children will not be permitted to attend school until we receive this form for our records.**

Does your child have any allergies, including seasonal allergies?      Yes      No  
If yes, please explain (if your child has seasonal allergies, please list his/her typical symptoms).

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any intolerances, such as lactose intolerance?      Yes      No

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

Does your child have any dietary restrictions?      Yes      No      If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any medical conditions?      Yes      No      If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child take any medications?      Yes      No      If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

(Please turn over and complete back of form).

We ask that you please notify your child's teacher if there is any change in their medication. Also, please note that the preschool teachers are not authorized to dispense medication. The only exception is an epi-pen (provided by the parent) which is used for life-threatening allergic reactions.

It is the expectation of the preschool that each child receives annual physicals and is up to date on their vaccinations. Please remember to submit a copy of your child's most recent immunization record with this form. Thank you!

### **Medical Treatment Authorization**

I confirm that the above information is complete and accurate. I hereby give the teachers permission to authorize medical care for my child, if, in an emergency, neither parent can be reached. It is my understanding that my child will be covered by my personal medical insurance. Payments for any medical injuries not covered by my insurance will be paid by me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date