

TELEPHONE: _____
CHILD'S NAME _____

CURRENT MEDICATIONS CHILD IS TAKING:

NAME OF MEDICATION PURPOSE FOR THE MEDICATION & DOSAGE

_____	_____
_____	_____
_____	_____

IF MEDICATION IS TO BE GIVEN DURING PROGRAM HOURS, WE WILL NEED INSTRUCTIONS AND PERMISSION FROM THE PRESCRIBING MEDICAL PERSONNEL.

PERSON OTHER THAN PARENT(S) TO BE NOTIFIED IN AN EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____ RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

TELEPHONE: _____ RELATIONSHIP: _____

DOES THE CHILD HAVE ANY ALLERGIES? IF SO, WHAT _____

WHAT ARE THE SYMPTOMS OF AN ALLERGIC REACTION _____

WHAT TREATMENT IS NEEDED _____

DATE: _____

PARENT/GUARDIAN SIGNATURE _____