

## Medical Information/Release

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Hospital of Choice \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Primary Insurance Coverage \_\_\_\_\_ Policy Number \_\_\_\_\_

Primary Insured Relationship to Child \_\_\_\_\_

List any medications your child is taking: \_\_\_\_\_

\*\*Allergies requiring medical attention (Food, Medicines, Bites, Plants, etc.) \_\_\_\_\_

**Allergy:** a medical condition that causes someone to become sick after eating, touching or breathing something that is harmless to most people

Are any of these allergies life threatening? (Yes/No)? \_\_\_\_\_

**\*\*If your child's allergies require medical attention, Mustard Seed Preschool will need an Allergy Action Plan from your child's physician prior to the first day of school. We are not able to dispense medication without the Allergy Action Plan.**

Please describe any current or past medical conditions or surgeries we should know about:

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

My permission is granted for the Mustard Seed Preschool's Director/Staff to obtain necessary medical attention in the event of an emergency or injury to my child. I understand that every effort will be made to contact me should such a situation occur. I also grant permission to the Director/Staff to obtain medical information from my \_\_\_\_\_ physician or any other institution or health care provider who has knowledge of my child's medical history. I understand that all information obtained will be kept strictly confidential and will be used only to aid Mustard Seed Preschool in better serving the needs of my child.

I also do hereby verify that the above information is correct and I do hereby release all employees of Mustard Seed Preschool and Christ Community Church from any claims and actions arising out of any damage or injury to my child while he/she is a participant/student of Mustard Seed Preschool.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_