MUSTARD SEED PRESCHOOL
A Mission of Christ Community Church

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: _____