Hope Lutheran Nursery School - Medical Form

Child's Full Name: _____ **Birthdate:**_____

Child's Primary Address: _____

_____

Names of Parents/Guardians:

_____ Phone Number: _____

_____ Phone Number: _____

Emergency Contacts: In the event of an emergency and neither parent can be reached, we authorize Hope Lutheran Nursery School to contact the following in the order listed:

#1 Name_____

Phone Number: _____

Relationship to child _____

#2 Name _____

Phone Number: _____

Relationship to child _____

#3 Name _____

Phone Number: _____

Relationship to child _____

#4 Name _____

Phone Number: _____

Relationship to child _____

Emergency Medical Treatment Consent:

In the case of a medical emergency, we understand that every effort will be made to contact a parent/guardian and the Emergency Contacts. In the event that none can be reached or that delaying treatment of our child would put them in danger, we hereby give permission to the staff of Hope Lutheran Nursery School to obtain emergency medical treatment for our child. We understand that we would assume all financial responsibility for any treatment deemed necessary in these circumstances.

We also give permission for the staff of Hope Lutheran Nursery School to share the information on this form with the emergency medical team.

Insurance Provider: _____

Policy Number: _____

Preferred hospital/treatment center: _____

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

Child's Full Name: _____

Child's Doctor/Physician Group: _____

Practice Address: _____

Phone Number: _____ Hospital Affiliation: _____

*** This part must be filled out and signed by a physician for all 3 year old and new 4 year old students.* For returning students, parents please make updates as needed. ***

Immunizations are current for age: yes or no (If no, please explain further below.)

_____

_____

_____

Please attach a copy of immunization records for new students.

Allergies	**Reaction**	**Treatment**
Food:		
Insect/Animal:		
Medication:		
Other:		

Description of any chronic medical issues, restrictions, or limitations:

List of daily medications needed by the child:

_____ _____

Doctor's Signature **Date**