Little Friends Early Learning and Child Care Center

Child Medical Form

Child's name:_____
First Middle Last

Age: _____ **Date of birth**: _____

Child's Doctor: _____

Doctor's Address: _____ Phone: _____

Child's Dentist: _____

Dentist's Address: _____ Phone: _____

Preferred Hospital: _____

Additional Information: (e.g., allergies, medications, medical conditions)

Medical/Physical: _____

_____

Developmental:_____

_____

Emotional/Social: _____

_____

Emergency Medical Care:

I hereby grant permission for Little Friends Early Learning and Child Care Center to secure necessary emergency medical treatment for_____ in the event that I cannot be reached to otherwise authorize the same.

Date: _____ Parent/Guardian signature: _____

Date: _____ Parent/Guardian signature: _____

Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Immunizations are up to date? Yes____ No_____

Please attach immunization records.