

Knightdale Baptist Preschool

MEDICAL FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES? (FOOD, MEDICINE, ENVIROMENT, ETC.):

DOES YOUR CHILD HAVE ANY PHYSICAL DISABILITIES OR LIMITATIONS?

IS YOUR CHILD ON ANY CONTINOUS MEDICATIONS?

CHILD'S DOCTOR: _____ PHONE NUMBER: _____

DOCTOR'S ADDRESS: _____

CHILD'S DENTIST: _____ PHONE NUMBER: _____

HOSPITAL PREFERENCE: _____

INSURANCE COMPANY: _____ POLICY NUMBER: _____

This form must be completed prior to registration. A copy of your child's immunization record must be submitted along with this form. State law requires this. Your child will not be allowed to start preschool if the immunization record is not on file with the Director.

I agree that the Director may authorize a physician other than the named doctor to provide emergency care to my child in the event that neither parent nor the child's doctor can be contacted immediately.

PARENT SIGNATURE: _____

DATE: _____