Medical Information

Does your child have any of the following:

Allergies: _____

Dietary Restrictions: _____

Any Special Needs: _____

Please list any operations or serious injuries (dates)
_____

Chronic or recurring illness/medical conditions:
_____

Potential allergy to insect stings? NO / YES, please be specific below

Asthma? NO / YES, If yes, does s/he carry an inhaler... NO / YES

Does your child carry an epi-pen? NO / YES If yes please indicate allergy.

Please NOTE: ALL medications that are administered to your child during his/her care with us, must have an "Authorization to Dispense Medication" form completed and presented with the medication in its ORIGINAL container.

To provide your child with a safe and stimulating environment for social, mental and physical growth, please list any fears or phobia's that may help us care for them.

I grant permission for staff to authorize and obtain medical treatment and /or transportation for my child in the event of an emergency or in the event that my child needs medical attention and I cannot be reached for authorization.
Parent Signature: _____ Date_____

Physician: _____ Telephone #:_____
Dentist: _____ Telephone #: _____
Preferred Hospital:_____
Insurance Company & Policy#:_____

I certify that the above named minor child is in excellent health and that there are no limits to my child's participation except as stated in writing on these pages. I further certify that the Cape Elizabeth School Department has on file all current immunization records for my child.

Parent's or Guardian's Signature _____Date_____

Preschool parents' MUST include a copy of your child's immunization records