FAIRLAWN BAPTIST CHURCH PRESCHOOL LEARNING CENTER
215 FAIRLAWN DRIVE.
PARKRSCBURG, W.V.26101
863-6782

Due to insurance requirements, ALL medical form must be signed by your physician and returned to preschool by Sept 1st. Children CAN NOT attend unless they have a signed medical form on file.

MEDICAL FORM

NAME: _____ PHONE: _____

ADDRESS: _____

BIRTHDATE: _____AGE: _____

MOTHER'S NAME: _____WORK PHONE: _____

FATHER'S NAME: _____ WORK PHONE: _____

MEDICAL HISTORY

Please mark if your child or a family member has had any of the following conditions:

	CHILD	FAMILY MEMBER
Chicken pox	_____	_____
Measles	_____	_____
German measles (rubella)	_____	_____
Mumps	_____	_____
Recurring ear infections	_____	_____
Recurring throat infections	_____	_____
Diabetes	_____	_____
Vision problems/glasses	_____	_____
Learning problems	_____	_____
Seizures	_____	_____
Asthma	_____	_____
ALLERGIES		
Hay fever	_____	_____
Mold and dust	_____	_____
Medications	_____	_____
Food	_____	_____

Please specify any Medication, allergies along with the type of reaction your child has:
_____
_____

Please specify any food environmental allergies your child has along with the reaction your child has: _____
_____
_____
.

Does your child take any medication on a regular basis? _____
_____
_____.

Date and descriptions of any hospitalizations, surgeries or serious injuries of your child:
_____
_____

Is there any other information we need to know to properly care for your child? _____
_____

In the event of an Emergency what hospital would you want your child to be taken to?

In caser of an emergency, please notify: (in the absence of Parents)

1. NAME:_____PHONE:_____

   RELATIONSHIP TO CHILD: _____

2. NAME: _____PHONE:_____

   RALATINSHIP TO CHILD: _____

If neither of the above persons is available in case of emergency, I give my permission for the Preschool Learning Center staff to obtain any necessary medical care until such a time as I can be reached.

Signature of Parent or Guardian

PHYSICIAN REPORT

Please list any physical or any medical conditions that may restrict activities, and list specific activities to be restricted, if any: _____
_____
_____
_____

Is this child free of communicable diseases at the time of examination?
YES_____ NO_____

Is the child's immunizations up to date? (Please attach a copy of records)
YES_____ NO_____

The above information is correct as of: (date) _____

Physician signature: _____

Physician address: _____
Physician phone: _____