

Medical Information

Date _____

Child's Name: _____

Does your child have any allergies? YES _____ NO _____

If YES, list the type of allergy(ies) being treated for, i.e., foods, environmental, adhesives (Band-Aids, etc.):

Current medications. If any, please list:

In the event your child has any minor medical complaints such as headache, do you want me to administer over the counter medications? If so, please check the following indicating your permission to administer:

- _____ Aleve
_____ Tylenol
_____ Ibuprofen

In the event of an emergency, please contact me at the following telephone number(s):

