Child's Medical Information Form

Child's Full Name: _____

Date of Birth: _____

Date of Care: _____

Primary Care Physician

- Doctor's Name: _____
- Clinic Name: _____
- Phone Number: _____
- Medical Insurance Provider: _____
- Policy/Member ID #: _____

Allergies

[ ] No known allergies

[ ] My child has the following allergies:

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- Reaction/symptoms: _____
- Medication or treatment needed: _____

Medications

[ ] My child is not currently taking any medications

[ ] My child takes the following medications:

- Medication Name: _____
- Dose & Time: _____
- Purpose: _____
- Instructions (include if needed during care): _____

Medical Conditions or Special Needs

[ ] None

[ ] Please describe any relevant medical conditions, developmental concerns, or accommodations needed:

Emergency Contacts (Other than Parent/Guardian)

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Parent/Guardian Signature

I confirm that the above information is accurate and complete. I give permission for caregivers to follow these instructions and contact emergency services if needed.

Signature: _____

Date: _____