McMannen UMC Preschool

Medical Emergency Form

Child's Name: _____ Birth Date: _____

Mother's Full Name _____ Father's Full Name_____

Home Address _____

Street City State Zip Code

Home Phone _____ EMail _____

Mother's Cell Phone _____ Father's Cell Phone _____

Mother's Workplace _____ Father's Workplace _____

Mother's Work Phone _____ Father's Work Phone _____

In case of emergency and the custodial parent cannot be reached, contact:

Name _____ Relationship _____

Address _____ Phone _____

Emergency Medical Consent

I give my permission for the Director and Teachers at McMannen United Methodist Church Preschool to secure medical assistance for my child while he/she is attending this school. I understand that efforts will be made to contact me in an emergency, but if I am unavailable, the decision related to securing medical assistance will be made by the Preschool staff in my absence.

Signature of parent or guardian _____Date _____

Family Medical/Hospital Insurance Carrier _____

Policy Number _____ Group Number _____

McMannen UMC Preschool

Health History

Child's Name: _____

Parent's Name(s): _____

Address _____

Name of Child's Physician _____ Phone _____

Date of Last Physical _____

Is this child currently under a physicians care for a medical problem? _____

If so, explain: _____

List any allergies this child may have (pollen, insect stings, etc.) _____

Please describe how the child is affected: _____

Prescribed routine for allergies: _____

Any special dietary needs? _____

Any limitations of activities? _____

Please list any other health concerns (nosebleed, motion sickness, etc.) _____

_____

Does your child take medication on a regular basis? _____

If yes, list medications _____

Does your child have any special needs of which you are aware?_____

McMannen UMC Preschool

History of Immunization

Child's Name: _____

Vaccine	Date of Each Dose (M/D/Y)			
	Dose #1	#2	#3	#4
Hemophilus Influenza B (Hib)				
Diptheria/Pertussis/Tetanus (DPT)				
Polio				[redacted]
Hepatitis B				[redacted]
Measles/Mumps/Rubella (MMR)		[redacted]	[redacted]	[redacted]
Varicella		[redacted]	[redacted]	[redacted]

Results of Tuberculin Test, if given: Type ____ Date _____ Normal ____ Abnormal _____

Provider Notes (To be filled out by Physician)

_____

_____

_____

Physicians signature:_____Date:_____

Address: _____Phone: _____

This health history is correct so far as I know, and the person herein described has permission to engage in all Preschool program activities except as noted.

Signature of Parent or Guardian _____ *Date* _____