Immunization Certificate is current until:_____

MOTHER'S DAY OUT

First Baptist Church
Murray, KY

Medical Form

Child's Name: _____ Age: _____ Birthdate: _____

Parent's Name(s):_____

Contact Numbers: _____

Emergency Contact (if parents are unreachable):_____

Emergency Phone Numbers: _____

Pediatrician's Name: _____ Phone: _____

Preferred Hospital:_____Phone:_____

Special Diet/Formula: _____ OR (circle) ____N/A_____

Medical Conditions and/or Allergies: _____OR (circle) ____N/A_____

Medications (if taken regularly): _____OR (circle) ____N/A_____

Sensory Concerns: _____OR (circle) ____N/A_____

I hereby give permission for _____ to receive emergency medical treatment if parent is unreachable and is deemed necessary by Mother's Day Out personnel of First Baptist Church. I understand that I will be responsible for any medical costs incurred at such times.

_____ _____

Parent Signature Date