



CHILD MEDICAL INFORMATION FORM

Child's Name: _____ **Date of Birth:** _____

Child's Physician or Clinic Name, Address, Phone:

ANY ALLERGIES (copy of Action Plan will be attached if provided)
MUST WRITE NONE, IF NONE KNOWN

MY CHILD HAS THE FOLLOWING SPECIAL NEEDS: _____

THE FOLLOWING SPECIAL ACCOMMODATIONS MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THE PRESCHOOL:

MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ILLNESSES OR HEALTH CONCERNS (IN ADDITION TO ANY ALLERGIES NOTED ABOVE):

TOPICAL OINTMENT & PREPARATIONS

I give SoulShine Preschool permission to dispense the checked topical ointments/preparations to my child in accordance to the directions on the label:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Baby wipes | <input type="checkbox"/> Band-Aids or bandages | <input type="checkbox"/> Neosporin or similar ointment | <input type="checkbox"/> Bactine or first aid spray |
| <input type="checkbox"/> Sunscreen | <input type="checkbox"/> Insect repellent | <input type="checkbox"/> Non-Prescription ointment (such as A&D, Vaseline) | <input type="checkbox"/> Cornstarch |
| <input type="checkbox"/> Aquaphor (for diaper rash) | <input type="checkbox"/> Coconut oil | | |

INSURANCE POLICY NUMBER:

(Please provide a copy of the front and back of your child's insurance card)



SOULSHINE PRESCHOOL MEDICAL EMERGENCY POLICY

In the event of a medical emergency SoulShine Preschool will attempt to contact the parents and/or designated emergency contact persons. If these individuals cannot be reached, “911” will be called in order to have the most immediate medical help available for the needs of the child. If a contacted individual cannot pick up the child, and there is a medical emergency, SoulShine Preschool will release the child to the paramedics. A staff person will accompany the child and paramedics to Children’s Healthcare of Atlanta (Egleston Hospital).

EMERGENCY MEDICAL AUTHORIZATION

Should _____, date of birth _____
suffer an injury or illness while in the care of SoulShine Preschool and they are unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian Signature Date

Parent/Guardian Signature Date

SoulShine Administrator Date