

# MEDICAL INFORMATION AND LEGAL RELEASE

Adopted by Freedom Preschool on 08/06/2019

Date\_\_\_\_\_

Child's Name\_\_\_\_\_ Date of Birth\_\_\_\_\_

Medical History (please include any major illnesses, broken bones, surgeries, diseases, hospitalizations, etc.) \_\_\_\_\_

Current Medications Given\_\_\_\_\_

Dosage\_\_\_\_\_

Time of Day Given\_\_\_\_\_

Known Allergies/Food Restrictions\_\_\_\_\_

Addition Information\_\_\_\_\_

## Emergency Contact

Mother's Name\_\_\_\_\_

Address\_\_\_\_\_

Phone (C)\_\_\_\_\_ (W)\_\_\_\_\_ (H)\_\_\_\_\_

Father's Name\_\_\_\_\_

Address\_\_\_\_\_

Phone (C)\_\_\_\_\_ (W)\_\_\_\_\_ (H)\_\_\_\_\_

Additional Emergency Contact (in the event parents may not be reached)

Name\_\_\_\_\_

Address\_\_\_\_\_

Phone (C)\_\_\_\_\_ (W)\_\_\_\_\_ (H)\_\_\_\_\_

Child's Doctor\_\_\_\_\_ Phone\_\_\_\_\_

Medical Insurance Company\_\_\_\_\_

Policy Insurance Number\_\_\_\_\_

I give permission for WesCare staff to make the emergency arrangement necessary for the care and welfare of my child while under their supervision. In a medical emergency, I understand that my child may be transported to an appropriate medical facility by emergency personnel for treatment if it is deemed necessary by staff. It is understood that in some medical and/or emergency situations, WesCare staff may need to contact medical and/or emergency personnel before the parent, child's physician and/or other adult acting on the child's behalf.

Signature of Parent:\_\_\_\_\_

Date:\_\_\_\_\_

**Permission for Healthcare**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Authorized Adults**

In the event of an emergency, please indicate your name and phone number where you and other authorized persons can be reached.

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Other Authorized Person \_\_\_\_\_ Phone \_\_\_\_\_

Other Authorized Person \_\_\_\_\_ Phone \_\_\_\_\_

**First Aid**

In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary for my child

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

**Emergency Care**

In the event of an emergency in which I cannot be reached the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Record Transfer**

In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_