JFNH PRESCHOOL
MEDICAL INFORMATION

CHILD'S NAME: ________________________ DOB __________________

PERTINENT INFORMATION REGARDING CHILD:

____

ALLERGIES:

____

MEDICATION:

____

Child's Physician:____

Address: _______________________________ Phone__________________

All Health Records must be completed and signed by a physician and submitted to the Jewish Federation no later than your child's first day at school.

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of the Jewish Federation Preschool to provide simple first aid treatment to my child____________________________ when necessary, and in the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

Parent Signature__________________________ Date___________________