PHYSICIAN'S INFORMATION:

Name of Physician _____ Office Phone _____

Address _____

List any food allergies _____

List any other allergies or medical conditions _____

_____

BACKGROUND INFORMATION:

Other Children in the Family:	Birthdate	School
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER:

Give below any other information you think we should know about your child: _____

_____

_____

_____

_____

I have received a summary of licensing requirements.

In case of an emergency, I hereby authorize emergency care for my child including First Aid or CPR administered by staff and/or authorize staff to call 911 if needed to administer additional treatment.

_____

Signature of Parent/Guardian Date