Ashland Child Development Center

Medical Information

NAME OF CHILD_____

1. Does your child have any food allergies? If so, please specify.

2. Is your child allergic to insect bites? If so, please specify.

3. Does your child take daily medications? If so, please specify.

4. Does your child have any special needs? If so, please describe.

5. If emergency medical care is necessary, I give my permission for any treatment deemed necessary by a physician and/or hospital of your choice.

_____ _____

Parent or Guardian's Signature Date

Preferred Hospital _____