

Does your child have any known allergies such as food, medications, plants or animals that we should be aware of? Yes No
If yes, please explain. _____

Does your child require medication to be administered during morning hours? Yes No
****If yes, please complete a Medication Administration Form.****

Does your child have any medical condition that we should be aware of while at the preschool? (I.e. asthma, allergies, etc.) Yes No
If yes, please explain. _____

Is there anything your child cannot eat? Yes No
If yes, please list. _____

Is there any food that you wish for child to not receive while at school? Yes No
If yes, please list. _____

Does your child have particular fears or anxieties of which we should be aware? Yes No
If yes, please explain. _____

Emergency Care Information:

Child's Doctor: _____ Phone: _____
Office Address: _____

If neither parent can be reached, whom should we contact in case of an emergency situation?

(Name)	(Relationship)	(Phone Number)
(Name)	(Relationship)	(Phone Number)

Parent Statement:

*With any pediatric emergency, children will be transported to Duke Medical Center. I agree that the Director may authorize the physician of her choice to provide emergency care in the event that neither I, nor the family physician can be contacted immediately. ****Please have both parents sign this form!!*****

(Parent Signature) (Date) (Parent Signature) (Date)