PRESCHOOL
OF DUNWOODY UNITED METHODIST CHURCH

MEDICAL CONDITION FORM

Please complete this form if you indicated your child has a <u>chronic medical condition</u> on the application.

If you indicated a food allergy, please complete the Food Allergy Action Plan instead.

CHILD'S NAME: _____,_____ **DATE OF BIRTH:** _____/_____/_____
LAST FIRST MONTH DAY YEAR

PARENT'S NAME: _____,_____ **PHONE:** _____
LAST FIRST

PARENT'S EMAIL ADDRESS: _____

PLEASE DESCRIBE THE CHILD'S MEDICAL CONDITION: _____

_____

_____

_____

_____

_____

WHAT IS THE TREATMENT? *If medicine is required, please also complete the Authorization for Administration of Medication form.*

_____

_____

_____

_____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION: _____

_____

_____

_____

PARENT'S SIGNATURE: _____ **DATE:** _____/_____/_____

PHYSICIAN'S NAME:_____ **PHYSICIAN'S PHONE:** _____

PHYSICIAN'S SIGNATURE:_____**DATE:** _____/_____/_____