

Please attach a copy of your child's Health Exam form administered by your child's physician.

CHILD MEDICAL FORM

Child's full name: _____
Last First Middle

Address: _____ Home phone: _____

Date of birth: _____ Age: _____

Mother: _____ Work phone: _____

Father: _____ Work phone: _____

EMERGENCY CONTACTS

Physician's name: _____ Phone: _____

Address: _____

Child's dentist: _____ Phone: _____

Child's health-care number: _____

Insurance Co.: _____ Policy #: _____

Hospital name: _____ Phone: _____

ADDITIONAL INFORMATION (e.g., **food allergies**, medication being taken, medication allergic to) _____

Medical: _____

Physical: _____

Developmental: _____

Emotional: _____

IMMUNIZATION RECORD

(Contact your local Health Care Professional for complete details before filling in this area.)

Please attach a copy of your child's Health Exam form administered by your child's physician.

Immunizations are up to date:

YES _____

NO _____

Has your child had:

Does your child suffer from:

Measles _____

Headaches _____

German measles _____

Ear aches _____

Chicken pox _____

Stomach aches _____

Mumps _____

Colds _____

Whooping cough _____

Flu _____

Other _____

Sore throat _____

Other _____

EMERGENCY MEDICAL CARE

I hereby grant permission for Prodigy Preschool/Staten Island Skating Pavilion
to secure the necessary emergency medical treatment needed by my son/daughter,

in the event that I cannot be reached to otherwise authorize the same.

Date: _____

Parent signature: _____

Parent signature: _____

Valid only for children with allergies

Child's name: _____

Allergic reaction signs: _____

Precautions/Recommendations: _____

Physician's name: _____ Phone: _____

Date: _____ Parent signature: _____