Medical Statement

Child's Name _____ Male ____ Female ____ DOB_____

Mother's Name_____ Father's Name_____

Contact Number_____ Contact Number_____

Home Address_____

Any allergies or special needs?_____
Food allergy? Yes___ No____ **If yes, doctor is required to also fill out and sign Food Allergy Emergency Plan on bottom portion.**

Attach your physician's copy of all state required immunizations and the date given.

The signature of your physician verifies that the attached immunization record dates are correct and this child is examined regularly by a physician and is able to participate in the Early Childhood Program.

➡ _____

Physician's signature **Address** **Phone#**

Food Allergy Emergency Plan

List of each food the child is allergic to:

_____

_____

Possible symptoms if exposed to a food on the list:

_____

_____

Steps to take if the child has an allergic reaction:

_____

_____

The signature below verifies that the Food Allergy Emergency Plan above is correct and can be posted for school use.

➡ **Parent Signature_____ Date_____**

The signature below verifies that the Food Allergy Emergency Plan above is correct.

➡ **Doctor Signature_____ Date_____**