

Patriots Place Student Medical Information Form
Please include an updated immunization record with this form.

Student's Name _____ Age _____ Birth date _____

- Please list any health/physical/developmental concerns that your student may have:

- Does your student take prescription medicine on a daily basis? Yes No

- If yes, please list medications and dosages: _____

- Does your student have life threatening allergies? Yes No

If yes, please list allergies and describe possible reactions: _____

Physician's Name _____ Phone Number _____

Hospital Preference _____

Is there anything else you would like us to know about your child? _____

*If your child has special dietary needs, they are free to bring their own healthy snack.

This information is accurate to the best of my knowledge, and the child herein described has my permission to engage in all activities. In the event I cannot be reached in an emergency, I hereby give permission to the director(s) of Patriots Place or designee to secure emergency medical services including transportation and a physician.

Parent/Guardian signature _____ Date _____