

**County Line United Methodist Church**  
Mother's Morning Out & Preschool Program  
Medical Information



**Child's Name:** \_\_\_\_\_

**Physician Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Please list any allergies that you child has:**

\_\_\_\_\_  
\_\_\_\_\_

**Medications currently taking:** \_\_\_\_\_

**Has your child had a serious illness, surgery, or hospital stay? If so, please give brief explanation of event and any long-term results from it, if necessary. (If you need more room, please use back of form)**

\_\_\_\_\_  
\_\_\_\_\_

**Does your child have any chronic illness?** \_\_\_\_\_

**Does this illness require special care?** \_\_\_\_\_

**I give permission for my child to have the following medicines administered, if needed:**

\_\_\_\_\_ Neosporin          \_\_\_\_\_ Caladryl Clear          \_\_\_\_\_ Bactine

\_\_\_\_\_ Benadryl Cream          \_\_\_\_\_ Bee Sting Treatment

Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Signature: \_\_\_\_\_