## Little Friends Early Learning Center

## **Child Medical Form**

Child's name:			
	First	Middle  Date of birth:	Last
Child's Doctor:			····
Doctor's Address:		Pho	
		Pho	
Preferred Hospital:			
Additional Informati	<b>on</b> : (e.g.	, allergies, medications, medi	cal conditions)
Medical/Physical:			
Emotional/Social:			
Emergency Medical	Care:		
I hereby grant permissi	on for Litt	tle Friends Early Learning and	d Child Care Center to
secure necessary emer	gency m	edical treatment for	
in the event that I canno	ot be read	ched to otherwise authorize the	ne same.
Date:	P	arent/Guardian signature:	
Date:	P	arent/Guardian signature:	
Insurance Carrier:			
Policy Number:		Group Number:	,
Immunizations are un te	n data2 V	as No	

Please attach immunization records.