Medical Information Form for
The Field Station Cooperative Preschool

Child	Legal Name	Home Address
	Preferred Name	City, State, ZIP
	Date of Birth	Gender
Parent/ Guardian	Name(s)	Home Address
	Phone	City, State, ZIP
Physician	Name(s)	Office Address
	Phone	City, State, ZIP

Child's Health Information - To be completed by the child's physician
Allergies (Including Food)
Current Medications
Vision Issues
Hearing Issues
Mobility Restrictions
Speech or Language Development Issues
Emotional or Behavioral Issues
Is the Child Currently Under Medical Treatment? If So, Why?
Any other medical conditions that may affect school participation or behavior

Health History	MM/DD/YYYY		MM/DD/YYYY
☐ Rheumatic Fever	___/___/_____	☐ Mumps	___/___/_____
☐ Measles	___/___/_____	☐ Diabetes	___/___/_____
☐ German Measles	___/___/_____	☐ Epilepsy	___/___/_____
☐ Chicken Pox	___/___/_____	☐ Other_____	___/___/_____
☐ Whooping Cough	___/___/_____	☐ Other_____	___/___/_____

PLEASE ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORDS TO THIS FORM

Physician's Signature **___/___/_____**

Please ensure that this form is signed and dated, then mail or deliver to:
The Field Station Preschool, 399 Howe Rd, Porter, IN 46304
For security reasons, please do not email personal medical information.