Crosby Methodist Weekday School

MEDICAL INFORMATION & PICK UP AUTHORIZATION FORM

Child's Full Name_____ **Date of Birth**_____ **Gender**_____

Parent/Guardian Name_____ **Telephone Number**_____

Parent/Guardian Name_____ **Telephone Number**_____

Please check any of the following special issues this child may have/ have had: (Mark **NONE**, if none apply)

__allergies (Medical Emergency Plan form may be required) __existing illness __previous serious illness

__injuries during the last 12 months __hospitalizations during the last 12 months

__other (explain below) **__NONE**

If any of the above are checked, please explain. Also*, please list any current and/or daily medications this child takes*.

_____

_____

Physician's Name_____ Telephone Number _____

Address_____

PARENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

By signing this form, I authorize Crosby Methodist Weekday School to contact the person(s) indicated on the back of this form in case of a medical emergency and a parent cannot be reached. I give consent for Crosby Methodist Weekday School to make arrangements for emergency medical attention in the event I cannot be reached.

Please be certain that the people listed are within a reasonable distance of the school and would be willing and available to pick up your child in the case of illness or emergency. Weekday School will always attempt to contact parent(s) first.

PICK UP AUTHORIZATION

In addition to the parent(s) of the above-named child, the only person(s) authorized to pick up my child from Weekday School without further permission are indicated on the back of this form.

By signing this form, I understand Weekday School will refuse to release my child to any person(s) other than those named below unless I have given my permission. Written permission notes for specific instances will be accepted. I understand that a picture ID will be required if the person(s) picking up my child is not known to Weekday School staff.

If there is any person(s) who is/are legally excluded from picking up your child, please provide legal documents.

By signing this form, I agree that I will leave my child at Weekday School ONLY in the presence of a staff member. I will not pick up my child from Weekday School without making a staff member aware of my child's departure.

Please indicate if each person below is authorized for Emergency Medical notification/pickup, Authorized pickup, or both by checking the applicable box(es).

Unless we have legal documents stating otherwise, parents are automatically assumed to be authorized for Emergency Medical or Authorized Pick Up.

Name	Complete Address	Phone Number	Relation to Child	Emergency Medical	Authorized Pick Up

Use space below or attach additional sheet if needed

Immunization Record

Choose one:

___ Current Immunization Record is attached

___ Current Immunization Record is already on file at school

___ My child has an upcoming well child appointment on _____ and will receive an updated record at that time

Well Child Form

Choose one:

___ Signed Well Child form is attached

___ My child has an upcoming well child appointment on _____ and will receive a signed Well Child form at that time.

Insurance Card

Choose one:

___ Insurance card is attached

___No insurance card

_____ _____

Signature of Parent/Guardian Date

2/7/2022