Beacon of Hope Child Care and Learning Center

Medical Information Release Form

Child's Name_____

Social Security Number_____Birthdate_____

Please check any items listed that pertain to your child and give an explanation below.

My child has a history with:

__ Asthma
__ Breathing Difficulty
__ Hives/Skin Difficulty
__ Kidney Problems
__ Hearing Problems
__ Speech Difficulty
__ Physical Limitations
__ Hyperactivity
__ Dyslexia
__ Seizures/Epilepsy
__ Allergies (List Below)
__ Aids (HIV)
__ Heart Problems
__ Intestinal Problems
__ Vision Problems
__ Coordination Difficulty
__ Emotional Trauma
__ Attention Difficulty (ADS)
__ Other (Explain)

Explanation for any of the above: _____

_____.

Does your child have a history of any type of abuse?___ Explain: _____

_____.

Is your child on any type of regular medication? ___ Explain: _____

_____.

Special instructions in case of an emergency: _____

_____.

Medical Insurance Co. _____Policy # _____.

Principal Insured: _____ Relationship to child: _____.

Physician: _____ Phone: _____.

I give permission for Beacon of Hope Child Care and Learning Center to get medical attention for my child in the event of an emergency situation.

Signature _____ Date _____