DAYDREAMS
DAYSCHOOL

MEDICAL RECORDS

Name of Child: ______________________________

Parent Initial: ______________ Date: ______________

Name of Child: ______________________________ Date of Birth: ______________________________

Mother's Name: ____
Address: ____
Home Phone: ______________________________ Cell Phone: ______________________________
Email Address: ____

Father's Name: ____
Address: ____
Home Phone: ______________________________ Cell Phone: ______________________________
Email Address: ____

Physician's Name: ____
Address: ____
Phone: ____
Insurance Information: ____
Child's Medical Record Number: ____

Chronic Illnesses: ____
____

Allergies: ____
____

Current Medications: ____
____

Special Information: ____
____

Please note: Complete Immunization records must be on file prior to your child's first day of enrollment.