Pleasant Valley Preschool

1990 Route 212
Quakertown, PA 18951
610-346-8262

www.pvpreschool.com
Board: pvpreschool@gmail.com
Teachers: pvpteachers@pvppreschool.com

Medical Information Form

Child's Name: _____ Date of Birth: _____

Copy of immunization records turned in: _____ Date: _____
Date of last tetanus shot: _____

Does your child have any of the following conditions? If yes, please explain the type of medical treatment.

Yes	No		
_____	_____	Food Allergy	_____
_____	_____	Drug Allergy	_____
_____	_____	Bee Sting Allergy	_____
_____	_____	Other Allergy	_____
_____	_____	Glasses (when to be worn)	_____
_____	_____	ADD/ADHD	_____
_____	_____	Asthma	_____
_____	_____	Diabetes	_____
_____	_____	Migraine Headaches	_____
_____	_____	Seizure Disorder	_____
_____	_____	Any Other Conditions	_____
_____	_____	Presently Taking Medication	

Name of Medication and Reason for Taking

_____
_____
_____
_____

Please update this form immediately if any information changes.

_____ _____
Date Parent or Guardian Signature

Please complete both sides of this form.

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Release Form

I _____, of _____
(Please PRINT Parent or Guardian Name) (Child's Name)

have read and agree to the following terms:

- I give permission for my child to receive emergency medical care if necessary.
- Intending to be legally bound, I release (except for any applicable insurance coverage) Pleasant Valley Preschool and Trinity United Church of Christ, and their officers, employees, agents, and volunteers from any and all suits, judgements, claims, contributions and demands whatsoever, arising out of or relating to the attendance and participation of my child named above in connection with any and all classes, events, and activities.
- If a medical condition has been identified on the Medical Information Form, please identify it here and it shall be hereafter considered part of this release form:
  _____
  _____
  _____
  _____

_____ _____
Date Parent or Guardian Signature

Please complete both sides of this form.