Blue Sky Kindergarten

3046 11th Street, Boulder, CO 80304, 303-443-9098

Medical Information Form

Please type or print all information

Today's Date: _____

Child's Name _____ Date of Birth _____

In case of emergency, call:

Parent #1

Name _____ Home Phone _____

Address _____

City/State _____ Zip _____ Cell/Pager _____

Employer _____ Work Phone _____

Employer's Address _____

Parent #2

Name _____ Home Phone _____

Address _____

City/State _____ Zip _____ Cell/Pager _____

Employer _____ Work Phone _____

Employer's Address _____

Additional local persons who can be called in emergency if parent cannot be reached:

Name _____ Relationship _____ Phone _____

Address _____ City/State _____ Zip _____

Name _____ Relationship _____ Phone _____

Address _____ City/State _____ Zip _____

Physician:

Name _____ Office Phone _____

Address _____ Emergency Phone _____

City/State _____ Zip _____

If Physician cannot be reached, the school should (check one):

_____ Call the nearest emergency hospital

_____ Other (please specify)

Dentist:

Name _____ Office Phone _____

Address _____ Emergency Phone _____

City/State _____ Zip _____

Medical Insurance Carrier:

Name _____ Group No. _____ ID No. _____

_____ No Insurance (please check if applicable)

MEDICAL BACKGROUND

List any allergies your child has, includng allergies to medications:

_____

_____

List and explain any continuing medication your child is taking:

_____

_____

What additional medical information should your child's teachers have for dealing with an emergency situation?

_____

_____

Has your child:

Been hospitalized at any time since birth? Yes ___No_ _____

For what? _____

_____

Had any surgery? _____

_____

Had any serious injuries (type and dates)? _____

_____

What serious illnesses are in the family history? _____

_____