



# Washington Street UMC Preschool

*Learning to Live Lovingly*

109 S. Washington Street

Alexandria, VA 22314

Tel. (703) 549-7931

wsumc.com/preschool

## Confidential Student Health Information

Please print clearly and complete this form in its entirety. Do not leave any fields blank.  
When appropriate, indicate "not applicable / NA".

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian #1 Name: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Parent/Guardian #2 Name: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

### MEDICAL INFORMATION

Physical Restrictions \_\_\_\_ **NO** \_\_\_\_ **YES** (Please explain on back of this form)

Medical Diagnosis/Conditions: \_\_\_\_\_

Other Health Conditions: \_\_\_\_\_

Date of Last Child Well-Visit/Physical Exam: \_\_\_\_\_

Currently prescribed medication and treatments: \_\_\_\_\_

Date of, and reason for, last hospital or emergency room visit: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

### ALLERGY INFORMATION

**Food Allergies:** \_\_\_\_ **NO** \_\_\_\_ **YES**

If YES, please list food(s): \_\_\_\_\_

Date of last severe food allergy reaction: \_\_\_\_\_

Please describe reaction: \_\_\_\_\_

**ALLERGY INFORMATION (Cont'd)**

Currently prescribed medication and treatments for food allergy(ies): \_\_\_\_\_

**Medication Allergies:** \_\_\_ NO \_\_\_ YES

If YES, please list medication(s): \_\_\_\_\_

Date of last severe medication allergy reaction: \_\_\_\_\_

Please describe reaction: \_\_\_\_\_

**Other Allergies (Bee Stings, Pollen, Latex):** \_\_\_\_\_ NO \_\_\_\_\_ YES

If YES, please list which: \_\_\_\_\_

Date of last severe allergy reaction: \_\_\_\_\_

Please describe reaction: \_\_\_\_\_

Currently prescribed medication and treatments for other allergy(ies): \_\_\_\_\_

**FOOD RESTRICTIONS**

Due to Gastrointestinal distress: \_\_\_ NO \_\_\_ YES

If YES, please list food(s) to avoid: \_\_\_\_\_

Due to religious or other preferences: \_\_\_ NO \_\_\_ YES

If YES, please list food(s) to avoid: \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**

The parent(s)/guardian(s) named above hereby authorizes Washington Street United Methodist Church Preschool to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and /or the administration of medication to his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when the parent(s) cannot be reached. Otherwise, parent/guardian can be expected to be notified immediately. Parent(s)/guardian(s) have read and understood Washington Street UMC Preschool's policy on the administration of medication as outlined in "Religiously Exempt Child Day Care Center Program Decision to Administer Medications".

The parent(s)/guardian(s) is responsible for notifying Washington Street UMC Preschool of any newly diagnosed medication and allergy conditions during the school year and providing any medication, special food, supplies or equipment that the student requires during the preschool day. If an individual health care plan is required, the parent/guardian, and the child's physician (when applicable) is required to provide all information in order to ensure the health and safety of the child while in the care of Washington Street UMC Preschool. Parents/guardians are responsible for

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_