first presbyterian church
PRESCHOOL

2024-25 Medical/Release Information

Office Use
Class: _____

Medication Alert: _____

IHCP Completion Date: _____

Student's Name: _____

Parents' Names: _____ Primary Phone: _____

Secondary Phone: _____

Field Trip Permission

I hereby give permission for my child to be taken on supervised field trips throughout the school year, by foot or by car. I understand that I will receive advance notice of all field trips.

_____
Parent Signature

Medical Release

If serious illness or accident occurs at school or other locations and neither parents nor person listed below can be reached, I/We give permission to the teachers and staff of First Presbyterian Preschool to secure medical care from our physician _____phone _____ or his/her associates, or from the most immediately available licensed health care professional. I/We accept full responsibility for any financial indebtedness related to transporting and treating my child at a hospital or medical clinic.

_____
Parent Signature

Other Authorized Pick-up Persons (Other than Parents. Please list at least 1 alternate pick-up person)

Name:	Contact Phone #1	Contact Phone #2	Relationship
1.			
2.			
3.			
4.			
5.			

Emergency Contacts - Contact in this priority (Other than Parents- Parents will always be contacted first!)

Name:	Contact Phone #1	Contact Phone #2	Relationship
1.			
2.			

OUT-OF-STATE EMERGENCY CONTACT

Name_____ Phone_____ Relationship_____

Does your child attend daycare or another school? Yes □ No □ If Yes: Name:_____

Phone #:_____

Please list the days of the week and times:_____

Please complete the Medical Information on the other side. Thank you.

Medical Information

Immunizations

A completed Immunization form or signed Certificate of Exemption must be on file in school office before your child can attend class. All immunizations must be on the Washington State Department of Health Certificate of Immunization form. These forms are available in the school office.

Medical History

Please check any of the following that may affect school performance or require special management/medication at school. If you check an item, please indicate whether medication for that condition is required at school, and if it is required, please list the medications.

- ☐ Medication allergies (Please List Medications) _____
  _____
- ☐ Allergies (requiring medication) _____
- ☐ Asthma (requiring medication)_____
- ☐ Physical Disability _____
- ☐ Medication regularly taken ***at home*** _____
- ☐ Blood disease _____
- ☐ Food Intolerance _____
- ☐ Contact lenses _____
- ☐ Eyeglasses _____
- ☐ Heart disease _____
- ☐ Rheumatic Fever _____
- ☐ Emotional/Behavioral Issues: _____
  Has the child seen a physician for this issue? _____
- ☐ Headaches/Stomachaches _____
- ☐ ADD/ADHD _____
- ☐ Convulsions/Seizures _____
- ☐ Epilepsy _____
- ☐ Kidney disease _____
- ☐ Hearing Loss _____
- ☐ Diabetes _____
- ☐ Nosebleeds _____
- ☐ Chronic Diseases _____
- ☐ Other _____

If you checked any of the above conditions, and medication is required at school for that condition, please refer to the checklist below to learn what we will need ***before your child can attend class.***

Information Needed for Students with Allergies

Allergy Reaction Information:

My child's allergic response is triggered by: ☐ Ingestion ☐ Touch ☐ Inhalation ☐ Other (Specify below)

Other allergic response trigger:

_____

Has your student ever experienced an episode of anaphylaxis requiring an EpiPen or hospitalization? ☐ No ☐ Yes

If yes, please list each incident including date:_____

_____

Please describe how the allergic response manifests itself in your student: _____

_____

Checklist for medication to be administered at school

The following items must be received *prior to the first day of school.*

- All medication must be submitted with a completed Health Care Provider's Order for Medication at School form.
- For students keeping medication at school, ***an Individual Health Plan must be completed with your child's teacher***.
- All prescription medication must have the pharmacy label with student's name attached to the medication.
- All over the counter medication must be in its original packaging.
- Please check expiration dates before bringing in medication. Medication must not expire during the school year.