



Bradley Preschool
210 W. Main Street, Greenfield, IN 46140
317-462-8858 preschool@bradleyumc.org

Student Medical Treatment Plan

Student Name _____ Birthdate _____

Parent Name _____ Best number to reach you at _____

Student's Doctor _____ Doctor's Phone Number _____

Description of the Medical Condition:

Symptoms to look for if the medical condition is beginning to occur or if the student is in pain:

Treatment Plan for student when necessary:

I, _____, give Bradley Preschool permission to
(parent's name)

(describe treatment) _____

for my child, _____.

Date _____

Parent Signature _____



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Medical Form

Parents: Please fill out the information in the top portion of this page and have your child's physician or the physician's assistant fill out the bottom portion of the page. Bradley Preschool requires that this form be turned in on or before **September 20** or within 30 days of registration for children who enroll midyear. Information from a well-child visit within the last year is satisfactory. Please do not wait until the last minute to get this form completed.

Child's Name _____ **Date of Birth** _____

Address _____ **Telephone** _____

To the Physician: Please complete the bottom portion of this page.

We require that the child be brought up-to-date on their state required immunizations. Please indicate the dates the following vaccines were given:

Diphtheria: _____ **MMR:** _____ **Poliomyelitis:** _____

Tetanus: _____ **Whooping Cough:** _____ **Varicella:** _____

Date of Physical Exam: _____

Height _____ **Weight** _____

Ears _____ **Eyes** _____

Heart _____ **Abdomen** _____

Nose _____ **Throat** _____

Does the child have any allergies? What is the allergy and what limitations should we place on the child in preschool?

Is the child subject to any conditions which might cause a classroom emergency? (For example, epilepsy, asthma, diabetes, etc.) Please comment:

Is there any physical condition which would limit participation in the classroom or play activities? Please comment. (Use the reverse side of this form if necessary):

Physician's Signature _____ **Date** _____

Return this form to:

Bradley Preschool
210 W. Main St.
Greenfield, IN 46140-2097
Fax 317-462-3211