

# Bradley Preschool Medical Form 2022-2023

Parents: Please fill out the following information. Bradley Preschool requires this form to be turned in on or before **Friday September 16<sup>th</sup>, 2022**. Up to date vaccinations records are satisfactory. A doctor's signature is required if your child has a medical/allergy treatment plan.

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

Address: \_\_\_\_\_ Contact #: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

*Vaccinations Required: must be filled out by Doctor and signed by doctor **or** provide shot record from the doctor's office.*

3 Hepatitis B: Dates: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

4 DTaP Dates: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

3 Polio Dates: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

1 Varicella Date: \_\_\_\_\_

1 MMR Date: \_\_\_\_\_

Recommended not required

Flu and 2 Hep A

**Doctor's Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

Please return to Bradley Preschool 210 W. Main St. Greenfield, IN 46140

Does your child have allergies? What allergy? Should the school place limitations on the child during school activities? \_\_\_\_\_

Is your child subject to any conditions which might make for a classroom emergency? (asthma, epilepsy, etc.) \_\_\_\_\_

IF you answered yes to any of the above please fill-out the back of this sheet and return with doctor's signature. Thank you.

## **Bradley Preschool Student Allergy/ Medical Treatment Plan**

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

Parent Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Doctor Contact Number \_\_\_\_\_

Allergy/ Medical Condition Name & Description

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Symptoms to look for \_\_\_\_\_

Things to avoid \_\_\_\_\_

Treatment Plan for student \_\_\_\_\_

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\*A Doctor verification note must be on file for any known life-threatening allergies .

Doctor's signature for treatment plan \_\_\_\_\_

Name Printed \_\_\_\_\_

Date of Note Attached \_\_\_\_\_

I, \_\_\_\_\_, give Bradley Preschool permission to treat my child,  
\_\_\_\_\_, as stated above in the treatment plan.

Date \_\_\_\_\_ Parent signature: \_\_\_\_\_

Printed name \_\_\_\_\_