

Troy Cooperative Preschool
CHILDREN'S MEDICAL INFORMATION

If your child needs medical, dental, hospital or other health services, you as parent must give permission. This form allows you to appoint adults who may be responsible for medical care for your children when you are not available. Fill out this form carefully.

Parents/Guardian

Name _____ Date: _____

Address: _____

Minor Children:

<u>Name</u>	<u>Birthdate</u>	<u>Allergies</u>	<u>Medical Problems</u>
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Medical Insurance Information

Company Name _____ Policy/Contract Number: _____

<u>Name</u>	<u>Phone</u>	<u>Name</u>	<u>Phone</u>
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Family Physicians _____

Sibling Over 18 Yrs. _____

Grandparents _____

Aunts/Uncles _____

I/We, being the parent(s) or legal guardian(s) of the above named minor children hereby appoint:

Troy Cooperative Preschool 6363 Livernois Rd., Troy, MI 48098 248.879.7601

To act in my/our behalf in authorizing unexpected medical care, dental care, and hospitalization for the above named minor(s) during the period of my/our absences, from:

_____ Month	_____ Day	_____ Year	Thru	_____ Month	_____ Day	_____ Year
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This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical care, dental care, and/or hospitalization may be required.

Parent/Guardian

Parent/Guardian

Signature

Signature

Address

Date

Address

Date

We, the parents, can be reached in an emergency:

Place _____

Telephone _____

