First United Methodist Church
217 South Church Street
Salisbury, NC 28144

704-636-3121
afterschool@fumcsalisbury.org

After School Child Care Medical Form

Name of Child_____Birthdate_____
(Last) (First) (MI) (Nickname)

Address_____

Email Address_____

Family Information

Mother/Guardian's Name_____ Home Phone_____

Address_____ Cell Phone_____

Place of Employment_____ Business Phone_____

Father/Guardian's Name_____ Home Phone_____

Address_____ Cell Phone_____

Place of Employment_____ Business Phone_____

Insurance Carrier_____ Policy #_____

Medical History (May be completed by parent)

Is child allergic to anything? No _____ Yes _____ If yes, what? _____

_____

Is the child currently under a doctor's care? No _____ Yes _____ If yes, for a what reason? _____

_____

Is the child on any continuous medication? No _____ Yes _____ If yes, what? _____

_____

Any previous hospitalizations or operations? No _____ Yes _____ If yes, when and for what? _____

_____

Any history of significant previous diseases or recurrent illness? No _____ Yes _____:

Diabetes No _____ Yes _____; Convulsions No _____ Yes _____; Heart Trouble No _____ Yes _____

If others, what/when? _____

_____

Does the child have any physical disabilities: No _____ Yes _____ If yes, please describe _____

Is there any additional information we should be aware of: _____

_____

Signature of Parent or Guardian _____Date _____