NURSERY MINISTRY
DUNWOODY UNITED METHODIST CHURCH

MEDICAL CONDITION FORM

Please complete this form if you indicated your child has a chronic medical condition on the application.

If you indicated a food allergy, please complete the Food Allergy Action Plan instead.

CHILD'S NAME: ______________________,_________________________ **DATE OF BIRTH:** _______/_______/________
LAST FIRST MONTH DAY YEAR

PARENT'S NAME: ______________________,________________________ **PHONE:** ______________________________
LAST FIRST

PARENT'S EMAIL ADDRESS: ____

PLEASE DESCRIBE THE CHILD'S MEDICAL CONDITION: ____

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WHAT IS THE TREATMENT? *If medicine is required, please also complete the Authorization for Administration of Medication form.*

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PLEASE PROVIDE ANY ADDITIONAL INFORMATION: ____

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PARENT'S SIGNATURE: ____ **DATE:** _______/_______/________

PHYSICIAN'S NAME:____________________________________ **PHYSICIAN'S PHONE:** _______________________

PHYSICIAN'S SIGNATURE:____**DATE:** _______/_______/_______