# BRIGHT HORIZONS MEDICAL INFORMATION FORM

**2022 - 2023 School Year**

Student's Name:_____ Grade: ___ (2022-23) DOB:_____

Does your child have any of the following? If yes, please explain below:

___Allergies ___Asthma ___Diabetes ___Heart Problems ___Seizures

___Other (_____)

Explanation:_____
_____

Does your child currently take any medications that program staff should be aware of? If yes, please list medications and explain:_____
_____

Has your child ever experienced any serious illness or injury that may limit her/his activity? If yes, please explain:_____

Does your child currently have a Health Action Plan on file at LCC School? If yes, please explain:_____

*As the parent or guardian, I authorize the BRIGHT HORIZONS and/or Laurel-Concord-Coleridge School staff to obtain and to direct emergency medical treatment by professional medical personnel to my child, while under the care of the BRIGHT HORIZONS Program, go to or from the Program, while riding in an authorized school district vehicle, or while participating in a BRIGHT HORIZONS activity.*

*I understand that I will be contacted as soon as possible in the event of an emergency.*

*I understand that the above information may be shared with appropriate staff members unless I notify the Program and/or School of my objection.*

_____ _____

Parent/Guardian Signature Date