Medical Conditions Form

CHILD'S NAME: ________________________, ____________________________
DATE OF BIRTH: ________/________/_________

PLEASE DESCRIBE THE CHILD'S MEDICAL CONDITION(S):

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WHAT IS THE TREATMENT? If medicine is required, please send student with medicine to self administer if possible

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PLEASE PROVIDE ANY ADDITIONAL INFORMATION:

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PARENT'S SIGNATURE: ____
DATE: ________/________/_________