The Brent Woodall Foundation for Exceptional Children
MEDICAL INFORMATION AND RELEASE FORM

Basic Information
Child's name: ________________________________ Child's DOB: ____________
Parent's Name: ____
Home Phone: _________________ Work Phone: _______________________
Cell Phone: ___________________ Email: ______________________________

Medical Information
Diagnosis: ____
Allergies: ____
Medications: Please include all prescription medications, over the counter medications, and vitamins/supplements.

Medication/Vitamin/ Supplement	Dosage	Purpose	Prescribing Physician

Communication:

☐Verbal Communicator ☐Minimally Verbal Communicator

☐Communicates with an AAC system ☐Gestural Communicator ☐Non-verbal

Behavioral Concerns:

☐Aggression to others ☐Self-injury ☐Child has a BIP

Emergency Contact Information
In case of an emergency, please contact (please indicate in the order they will be contacted)
1. Name: ___________________ Relationship: _____________ Phone: _________________
2. Name: ___________________ Relationship: _____________ Phone: _________________

I give the Brent Woodall Foundation permission to administer First Aid/CPR to my child if an emergency situation arises.
Parent Signature: _____________________________ **Date:** ____________________

I have reviewed the above information and verified it is current.
Parent Signature: _____________________________ Date: ____________________
Parent Signature: _____________________________ Date: ____________________
Parent Signature: _____________________________ Date: ____________________