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 have reviewed the above information, verified it is current and give the Brent Woodall Foundation permission to administer First Aid/CPR to my child if an emergency situation arises.

Parent Signature: __________________________________ **Date:** _____________________

For Future Updates: I have reviewed the above information and verified it is current.

Parent Signature: ______________________________ Date: ____________________

Parent Signature: ______________________________ Date: ____________________

Parent Signature: ______________________________ Date: ____________________