



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_

Please Provide a Contact Number: \_\_\_\_\_

Please list the facility name and type of form (ex: BAR-T Camp Form, JDS School, etc.): \_\_\_\_\_

- Have you completed your portion of the forms? Yes \_\_\_
  - Please ask if you're unsure about what section you need to complete.
- Is your child currently taking any medications? Yes \_\_\_ No \_\_\_
  - a) If yes, please list all medications and dosages. Including any over the counter, herbal, vitamins, or sports supplements.
   
\_\_\_\_\_
   
\_\_\_\_\_
  - b) Will these medications be taken at school/camp/daycare? Yes \_\_\_ No \_\_\_
  - c) If yes, are there specific times the medication needs to be given? Dosages?
   
\_\_\_\_\_
   
\_\_\_\_\_
- Does your child have any allergies to food or medications? Yes \_\_\_ No \_\_\_
  - a) If yes, please list below.
   
\_\_\_\_\_
   
\_\_\_\_\_
- Is there anything else that you would like the school/camp or daycare to know about your child?
   
Yes \_\_\_ No \_\_\_
   
\_\_\_\_\_
- Does your child wear eyeglasses or contact lenses? Yes \_\_\_ No \_\_\_
- Does your child wear braces? Yes \_\_\_ No \_\_\_

**HOW WOULD YOU LIKE TO RECEIVE THE FORMS BACK?**

Please select **one** option from below.

1. \_\_\_\_\_ Receive a call to pick up
2. \_\_\_\_\_ Receive a **text** to pick up – Please provide cell #: \_\_\_\_\_
3. \_\_\_\_\_ Mail Home                      Please Provide Home Address: \_\_\_\_\_
   
\_\_\_\_\_
4. \_\_\_\_\_ Fax\* to School/Camp/Daycare – **Please do not select this option if you wish to review the forms prior to submission to school/camp/daycare**
5. \_\_\_\_\_ Fax\* to Home/Work      \*Please Provide Fax Number: \_\_\_\_\_

\*I authorize Potomac Pediatrics to fax my child's forms to the provided fax number above. Initial: \_\_\_\_\_