

Dental Care Provider: _____ Name _____

Street Address _____ City, State, Zip _____ Telephone _____

Health Insurance Provider: _____

Certificate of Immunization: Yes No N/A Please explain: _____

My child has the following health conditions such as allergies, asthma, diabetes, epilepsy, etc., and/or takes the following medications on a regular basis:

Additional Comments: _____

I certify that to the best of my knowledge _____ Child's Name _____

is in good mental and physical health and able to participate in the child care program at _____

_____ Name of Child Care Facility _____

Signature: _____ Parent or Guardian _____ Date: _____

Signature: _____ Director/Operator/Staff Designee _____ Date: _____

GENERAL RECORD AND STATEMENT OF CHILD'S HEALTH FOR ADMISSION TO CHILD CARE FACILITY

This form is to be completed for each child at the time of enrollment in the child care facility, updated annually thereafter, and maintained on file at the facility.

GENERAL INFORMATION: (to be completed by Parent or Guardian)

Name of Facility: _____ County: _____

Address: _____ Street Address - no Post Office Boxes _____ City, State, Zip _____

Child's Name: _____ Last _____ First _____ Middle Initial _____ Nick Name _____

Date of Birth: _____ Enrollment Date: _____

Child's Current Home Address: _____ Street Address _____ City, State, Zip _____

Parent/Guardian's Full Name: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Parent/Guardian's Full Name: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

You must have two individuals who have the authority to obtain emergency medical treatment for the child.

1. Person responsible if parent/guardian unavailable for emergency medical services:

Full Name _____ Relationship _____

Address: _____ Street Address _____ City, State, Zip _____

Telephone Number(s): _____ Family Code Word(s): _____

2. Person responsible if parent/guardian unavailable for emergency medical services:

Full Name _____ Relationship _____

Address: _____ Street Address _____ City, State, Zip _____

Telephone Number(s): _____ Family Code Word(s): _____

Is Child currently enrolled in school? (5K up to 6 years old) Yes No

My Child will regularly attend this facility FROM _____ am/pm TO _____ am/pm

If Child is a drop-in, indicate hours of care: FROM _____ am/pm TO _____ am/pm

Check all days Child will regularly attend this facility: Mon Tue Wed Thurs Fri Sat Sun

Check all meals Child will receive daily: Meals are not offered Breakfast Morning Snack Lunch

Afternoon Snack Dinner Evening Snack

HEALTH INFORMATION: (to be completed by Parent or Guardian)

Family Physician or Health Resource: _____ Name _____

Street Address _____ City, State, Zip _____ Telephone _____

Emergency Care Provider: _____ Emergency Facility Name _____

Street Address _____ City, State, Zip _____ Telephone _____