Medical Form

Basic Information

Name of child_____Birth date_____

Child lives with ___Mother___Father___Other_____

Other children living with child:

Name_____Age_____Sex____

Name_____Age_____Sex____

Name_____Age_____Sex____

Health History

Any illness child has had or has? (Asthma, Chicken pox Diabetes, Epilepsy, Measles Mumps, Pneumonia, Strep Throat, Whooping Cough or Other)_____

_____

Allergies? (food, drug, bee strings, etc.) List type, symptoms and treatment required_____

_____

Immunization-Copy of immunization record needs to be attached and signed by doctor___

Does your child have any special needs that require accommodation by the provider? If so, please list_____

Does your child have a condition that, according to current medical information, would pose a direct threat to the safety of the others in the program? _____

Does your child have any functional limitations? (Functional limitations can include, but not limited to, limitations dealing with hearing, seeing breathing, speaking, learning, working, performing manual tasks, caring for oneself, social skills, and behavioral actions.) If so, please list_____

Developmental Background

Name of previous child care programs attended_____

Does child have any special problems/fears? _____

Child's favorite foods, activities? _____

Child's nap pattern_____

Child's favorite toy or blanket_____

Toilet habits_____

Child's eating habits_____

What makes the child frustrated or upset? _____

Family rules that provider should know about? _____

What methods of discipline do you find works best for your child_____

_____

Medical Emergency Consent

Name of child's physician or health clinic_____

Address_____Phone_____

Medical insurance company_____policy#_____

Name of child's dentist_____Phone_____

Child's hospital_____Phone_____

When there is a medical emergency, or when a child needs immediate medical treatment, the provider will take all reasonable steps to see that the children in her care receive adequate medical care. When appropriate, the provider will call 911 and the parent(s). If the parent(s) cannot be reach, the provider will call the person(s) listed below who are authorized by the parent to give permission for the medical treatment of the child. These person(s) authorized to do so are:

Name_____Phone_____

Name_____Phone_____

If the parent(s) and the authorized person(s) cannot be reached, the provider will call the child's doctor, identified above. If the child must be taken to the hospital, the provider will take the child to the child's hospital identified above. If under the circumstances, it is more reasonable to bring the child to another hospital, the provider will do so. In the situation where the parents(s) and the person(s) authorized to give permission for medical treatment are not able to be reach, the parent authorizes the child's doctor to provide the appropriate medical treatment for the child.

Provider's signature_____Date_____

Mother_____Date_____

Father_____Date_____