



CHILD INFORMATION

Child's Name: _____

Start Date: _____

Withdrawal Date: _____ Date of Notice: _____

Parent Contract Signed: Yes No

Date of Birth: _____ / _____ / _____

Health Care#: _____

Mother's Name: _____

Home Phone # _____

Place of Employment: _____

Work Phone #: _____

Cell Phone # _____

Father's Name: _____

Home Phone # _____

Place of Employment: _____

Work Phone #: _____

Cell Phone # _____

Family Home Address: _____

Guardian's Name: _____

Home Phone # _____

Place of Employment: _____

Work Phone #: _____

Cell Phone # _____

EMERGENCY INFORMATION

Emergency Contacts (2):

1. Name: _____
Address: _____
Phone #: _____(h) _____(w) _____(cell)

2. Name: _____
Address: _____
Phone #: _____(h) _____(w) _____(cell)

MEDICAL INFORMATION

Physician Name: _____
Clinic & Address: _____
Phone #: _____

Who will be picking up your child? _____

If this person is someone other than a 'legal' parent/guardian, it is a requirement of the Day Care Act and Regulations that written consent be on the child's file.

Is written consent on file? _____ Is it current? _____

If the answer is 'no', please provide the necessary consent or the individual will be refused.

Thank you.

MEDICAL HISTORY OF ILLNESSES

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Injuries |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Measles (German) | <input type="checkbox"/> Croup | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Measles (Red) | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Earaches | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Other _____ |

IMMUNIZATIONS

Are your child's immunizations up-to-date? Yes No

If yes, what are they? _____

Does your child have any know food allergies? Yes No

If yes, what are they? _____

Does your child have any other allergies? Yes No

If yes, what are they? _____

OTHER MEDICAL CONDITIONS

Does your child take any medications on a regular basis? Yes No

If yes, what medication, condition is it taken for, and what is the frequency and size of dosage?

1. _____
2. _____
3. _____
4. _____

Does your child have any congenital deformities? Yes No

If yes, please give details. _____

Are there any restrictions on the kind and/or amount of physical activity your child may participate in? Yes No

If yes, please give details. _____

Has your child ever undergone surgery? Yes No

If yes, please provide details. _____

Special Comments:
