

CHILD'S RECORD

Enrollment Date _____

Initial Placement Date _____

Child's Name:	Nickname:	Sex:	Birthdate:
Address:	City, State, Zip:		Telephone:

Mothers Name: _____ Occupation: _____
 Home Address: _____ Phone: _____
 Work Address: _____ Phone: _____

Fathers Name: _____ Occupation: _____
 Home Address: _____ Phone: _____
 Work Address: _____ Phone: _____

Others in household:

Name	Age	Relationship

Additional persons who may be called in the event of an emergency, and who are authorized to remove the child from the facility. (Your child will not be allowed to leave with any other person without written authorization from parent or guardian).

Name	Address	Telephone	Relationship

Physician or Dentist to be called in emergency

Physician:	Address:	Medical Plan &/or Policy #	Telephone:
Dentist:	Address:	Medical Plan &/or Policy #	Telephone:

If Physician cannot be reached, what action should be taken?

_____ Call Hospital _____ other Explain: _____

Which hospital do you prefer? _____

Past illnesses - Check those child has had and approximate date.

<input type="checkbox"/> Chicken Pox	Date	<input type="checkbox"/> Hay Fever	Date	<input type="checkbox"/> Whooping Cough	Date	<input type="checkbox"/> Ten Day Measles (Rubeola)	Date
<input type="checkbox"/> Asthma		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Mumps		<input type="checkbox"/> Three Day Measles (Rubella)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Polio-myelitis		<input type="checkbox"/> Other serious illness/ accident	

Does your child have any special problems or fears? Explain: _____

Are the problems serious enough to restrict our child's activities? Yes ___ No ___

Explain: _____

Describe, if any, special care required: _____

Does your child have frequent colds? Yes ___ No ___ How many in the last year? _____

List any allergies staff should be aware of: _____

Is your child currently taking prescribed medication? Yes ___ No ___

If yes, for what reason? _____ Is it a chronic illness? Yes ___ No ___

What is the name of the medication? _____

What do you plan to do when your child is ill? _____

Reason for requesting day care placement: _____

CONSENT FOR MEDICAL TREATMENT

In an emergency, _____ (Providers Name) has my permission to call an ambulance or to take my child to any available physician or hospital at my expense. Yes ___ No ___

In an emergency, my child may receive first aid Yes ___ No ___

In an emergency, the above named person has my permission to call Dr. _____ at (phone number) _____ and, if necessary, give consent to any doctor or hospital to administer medical or surgical treatment and care for my child at my expense. Yes ___ No ___

Signature of Parent or Guardian

Date