

Child Admission Agreement & Health Assessment

Name of Child _____ Enrollment Date ____/____/____
 Nickname _____ Birthdate ____/____/____ Sex (circle one) F M
 Home Street Address _____ Phone # _____
 City _____ State _____ Zip _____
 Mother's/Guardian's Name _____ Phone # _____
 Employer _____ Work Phone # _____
 Father's/Guardian's Name _____ Phone # _____
 Employer _____ Work Phone # _____

Emergency Contacts (Other than Parents) and Persons Authorized to Pick -Up the Child

Name	Relationship to Child	Address	Phone #
Out of Area/State Contact (If available.)	Relationship to Child	Address	Phone #

In case of emergency or serious illness, when parents cannot be reached immediately, I hereby authorize the provider to obtain emergency medical care and / or provide emergency medical transportation for my child.

_____ /____/____
 Signature of Parent or Guardian Date

I hereby give the provider permission to transport my child in the provider's vehicle for the following (optional):

- To and From School On Field Trips Other: _____

_____ /____/____
 Signature of Parent or Guardian Date

*This form must be completed for each **individual** child enrolled, and must be reviewed annually by the parent/guardian, and any changes noted.

(See reverse side for required Health Assessment.)

This form is provided as a technical assistance suggestion only. Providers are not required to use this form.

Child Health Assessment

Please Write Clearly

Name of Child _____ Birthdate ____/____/____

Check All That Apply:

Does your child have any known allergies or sensitivities to:

	No	Yes	If yes, please list:
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foods	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Illnesses or Medical Conditions:

Does your child have any of the following:

	No	Yes		No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral or Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

List any additional health information or special instructions you feel we need to be aware of:

List any regular medications your child takes: _____

Name of Child's Medical Provider: _____

Phone Number and Address of Medical Provider: _____

Name of Child's Dentist: _____

Phone Number and Address of Dentist : _____

Date of Child's Last Medical Exam: ____/____/____ Date of Child's Last Dental Exam: ____/____/____

Parent / Guardian Signature _____ Date _____

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