CHILD’S MEDICAL INFORMATION

Child’s Physician or Clinic’s Name (Child’s Primary Health Source)

____

Does your child have allergies or other physical problems, mental health disorder, mental retardation or developmental disabilities, which would limit the child’s participation in the center’s program and activities?

( ) Yes ( ) No If yes, specify: ___________________________________

Does your child have allergies (insects, medications, food, etc.)? ( ) Yes ( ) No

If yes, specify: ____

Are there any special procedures required in caring for your child? ( ) Yes ( ) No

If yes, specify: ____

________________________________ ____________________

Parent or Guardian Signature Date

Doctor’s Name: ______________________________ Phone #: ________________

List person(s) authorized to sign your child out from childcare:

Name: __________________ Relationship: ______________ Phone #: ______________

Name: __________________ Relationship: ______________ Phone #: ______________

Name: __________________ Relationship: ______________ Phone #: ______________

Name: __________________ Relationship: ______________ Phone #: ______________

Name: __________________ Relationship: ______________ Phone #: ______________