CHCCC HEALTH INFORMATION

Child's Name_____Birthdate_____

Mother_____Work Phone_____

Father_____Work Phone_____

EMERGENCY: If parents cannot be reached, contact:
Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Physician: Regular Medications:
Name_____ _____

Phone_____

Date of last physical exam_____

Date of last dental exam_____

Date of last eye exam_____

Does this child have any specific health problems, which the staff should be aware of? (Vision or hearing loss, allergies, including drug reactions, convulsions, seizures, etc.?)
Yes _____No_____If yes, please explain._____

Has your child had any serious illnesses that might affect their participation in day care activities? (Accidents, surgeries or communicable diseases such as measles, mumps, chicken pox, etc.)_____

Primary Medical Insurance Coverage_____
Dental_____Eye_____
Employer_____
Group Number_____Membership Number_____
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CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

_____, the natural parent/guardian of _____ authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. This includes emergency first aid and CPR by qualified childcare staff.
Signature _____Hm Phone_____Work_____
Address_____