Child Admission Agreement & Health Assessment

Name of Child	Nickname	Birth Date month/day/year	Sex (check one)	Enrollment Date (check the box if no longer enrolled)
		___/____ /_____	F ☐ M ☐	___/____ /_____ ☐
		___/____ /_____	F ☐ M ☐	___/____ /_____ ☐
		___/____ /_____	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
(Unless there is a court order prohibiting it, parents whose names are not listed can pick up their children.)

Name	Relationship to Child	Address	Phone #

☐ Check if there are no emergency contacts available, other than parents.
☐ Check if there are no persons authorized to pick up the child, other than parents.

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

☐ Check if there are no out of area/state contacts available.

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 (with written permission in advance) ☐ Other:______________________________

____ ______/______/___________
Signature of Parent or Guardian Date

(See reverse side for required Health Assessment.)

This form is provided for technical assistance purposes only. Providers may use this form if they choose, but are <u>**not**</u> required to use this form.

Child Health Assessment

Please Write Clearly. There must be a separate health assessment form for each sibling.

Name of Child ____ Birth Date ______/______/___________

Check All That Apply:

Does your child have any known allergies or sensitivities to:

	No	Yes	If yes, please list:
Medications	☐	☐	____________________
Foods	☐	☐	____________________
Other	☐	☐	____________________

Illnesses or Medical Conditions:

Does your child have any of the following:

	No	Yes		No	Yes
Asthma	☐	☐	Visual Impairment	☐	☐
Diabetes	☐	☐	Developmental Delays	☐	☐
Seizures	☐	☐	Physical Impairment	☐	☐
Heart Problems	☐	☐	Behavioral or Emotional Problems	☐	☐
Hearing Impairment	☐	☐	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: ____

____ ______/______/______

Parent / Guardian Signature Date

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

Reviewed and/or update: ______/______/______ Parent/Guardian Signature: ______________________________________

Reviewed and/or update: ______/______/______ Parent/Guardian Signature: ______________________________________

Reviewed and/or update: ______/______/______ Parent/Guardian Signature: ______________________________________

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