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 **not** 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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