

CHILD RELEASE AND EMERGENCY CONTACTS LIST

(Please PRINT clearly)

Child's Name	<u>Code Word</u>
Child's Physician	Phone #
Physician's Address	Zip
Preferred Hospital	
Child's Dentist	Phone #
Insurance Company	
Policy Holder	
Group Number	
Policy ID	

Emergency Contact (yes / no)	Release (yes / no)	Name	Relationship	Home Phone	Work Phone	Cell Phone

Food Allergies
Other Allergies / Sensitivities

Signed	Date
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HEALTH RECORD

To Be Completed By Parent (please print):

Child's Name	Birthdate / /
Physician's Name	Phone
Child's Height: inches	Child's Weight: lbs.

ILLNESS HISTORY	OPERATIONS
<u>Date</u>	<u>Date</u>
Chicken Pox	Tubes in Ears
Measles	Tonsillectomy
Mumps	Appendectomy
Rubella	Adenoidectomy
Whooping Cough	Mastoidectomy
Pneumonia	

Existing illnesses/injuries?
Currently taking medication?
Vision impairment or eye infection?
Hearing impairment or ear infection?
Speech problems?
Currently in any type of therapy?
Previous serious illnesses/injuries?
Hospitalized in last year?
Any previous therapy?
Parent Concerns / Comments:

Signed _____ Date _____

CARE INSTRUCTIONS AND BACKGROUND INFORMATION

CHILD'S NAME	DATE / /
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FEEDING

Does your child take a bottle?
Should the bottle be warmed?
Can your child hold a bottle?
Does your child eat:
Formula
Whole Milk
Strained Foods
Junior Foods
Table Foods
Other
Any food likes?
Any food dislikes?
Does your child use a pacifier? When?
Approximate daily bath time?
Approximate nap time(s)?
Special nap requirements?
Is your child toilet trained?
Does your child wear diapers at naptime?
What brand/type of diaper do you use?
Do you use powder?
Can Desitin or Vaseline be used for diaper rash?

How does child indicate need for toilet?
What word does your child use for urination?
What word does your child use for bowel movement?

FAMILY

Marital status of parents?
How long?
If separated, who has custody?
Is your child adopted?
Does child know?
Is a language other than English spoken at home?
Does either parent have an interesting occupation/hobby/talent?

SOCIAL / DEVELOPMENTAL

Age at which your child:
Crept on hands and knees
Sat alone
Named simple objects
Repeated short sentences
Began toilet training
Can your child dress self?
Can your child undress self?

(over)

Is your child right or left handed?
Does your child sleep well?
Favorite indoor play activities?
Favorite outdoor play activities?
Does your child play with water?
Any fears you are aware of?
Speech, sight, or hearing problems?
Attended nursery school before? Where? How long?
What behavior control do you use?
What is your child's usual reaction?
Which parent administers punishments?
Describe your child's personality
Your child's activity level?
Is your child:
Read to regularly?
Favorite story / Book?
Interested in music?
Favorite record / tape?
Has your child had experience with:
Clay
Scissors
Easel
Painting
Finger painting
Blocks
Is play usually adult supervised?
Outdoor play restricted to home yard?

Does your child know others at Child's Day? Who?
Is your child Friendly Aggressive Withdrawn
Are playmates girls / boys; younger /older?
Does your child: Get along well with other children? Accept new people easily?
Have any nervous habits? When are they likely to show?
Need special help with anything?

HEALTH

Does your child have frequent
Colds?
Ear aches?
Stomach aches?
Does your child vomit easily?
Does your child run high fevers easily?
Has your child ever been to a dentist?
Does your child wear corrective shoes?

COMMENTS

Signed
Date

AUTHORIZATION TO PROVIDE
PHYSICIAN'S MEDICAL REPORT

To:

Please print

_____	Physician Name
_____	Medical Practice Name
_____	Address
_____	City, State, Zip
_____	Phone Number
_____	Fax Number
_____ . . .	Dr.'s Email Address.
.

You are authorized to provide our child care center with the medical and immunization information requested with this page.

Please print:

Child's Name	Birth Date
Parent's Name(s)	
Address	

Signed _____

PHYSICIAN'S MEDICAL REPORT

To Be Completed By Parent:

CHILD'S NAME	BIRTHDATE
PARENT'S NAME	
PHYSICIAN	
RETURN BY MAIL TO: CHILD'S DAY 2525 WALLINGWOOD DR #100 AUSTIN TX 78746	OR FAX TO: 327-3281
SIGNED	DATE

To Be Completed By Physician:

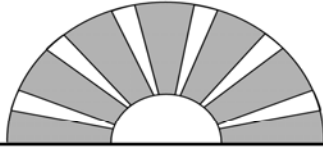
IMMUNIZATION DATES					
(Please show Mon/Day/Year)					
	#1	#2	#3	#4	#5
DTaP					
POLIO					
PCV					
HiB CV					
Hep B					
Hep A					
MMR					
VARICELLA					

Tb TEST	DATE:	RESULT:	<input type="checkbox"/> pos.	<input type="checkbox"/> neg.
(OTHER)				

Are any restrictions on normal physical activities indicated?
Does any chronic medical condition necessitate dietary supplements, restrictions or medication?
Known allergies:
Date of last examination:

We consider this child to be up-to-date on immunizations and able to participate in the child care center program at this time.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____



Child's Day

Preschool · Kindergarten · Child Development Center

2525 Wallingwood Drive # 100 • Austin, Texas 78746
Phone: (512) 327-3274 • FAX (512) 327-3281

Periodically, the State of Texas licensing personnel, NAEYC evaluators, medical personnel providing emergency treatment to your child, or your child's teacher may have a need to review your child's file which includes information about your medical plan and certain medical conditions that you may have reported to Child's Day.

Based on our records confidentiality policy, we will not share health insurance or medical information with any individual or institution unless you expressly give us permission to do so.

Please review the following options, **sign your initials** if you would like us to release medical and health insurance information, sign/date, and return this form. If you do not want us to release information about your child's medical conditions or health information, please print "**decline**" on the appropriate line.

Thank you.
Child's Day

_____ I authorize Child's Day administrative and management staff to release medical information and health insurance information for my child _____ to medical personnel, health care professionals or medical treatment centers when required for medical treatment for my child.

_____ I authorize Child's Day administrative and management staff to release medical and health insurance information for my child _____ as needed to comply with NAEYC accreditation standards or State of Texas Licensing requirements.

Name

Date