Child's Health and Emergency Information for Family Child Care Homes

PHHS CCF FORM

(To be completed by the child's parent or guardian)

Date of Application: _____ Date of Enrollment: _____

Information on Child

Child's Name_____ Name Called_____ Birthdate_____

Address_____ Home Phone_____

Parent/ Guardian's Name_____ Parent/ Guardian's Name_____

Home Address_____ Home Address_____

Home Phone_____ Home Phone_____

Workplace_____ Workplace_____

Work Phone_____ Work Phone_____

Person(s) responsible for pickup and delivery_____

_____

Other person(s) allowed to pick up child from child care home_____

_____

In case of emergency when a parent cannot be reached, please notify:

1. Name_____ Phone_____
   Address_____ Relationship_____

2. Name_____ Phone_____
   Address_____ Relationship_____

3. Name_____ Phone_____
   Address_____ Relationship_____

Please give specific instructions if your child needs special assistance, equipment, or materials to participate in activities.

_____

List any allergies your child may have:_____

_____

What are your child's favorite toys, games, and food?_____

_____

Other important information about your child_____

_____

Illnesses

Check the following illnesses that your child has had:

? Mumps ? Chicken Pox ? German Measles

? Red Measles ? Rheumatic Fever

Check recurring problems that your child may have:

? Bronchitis ? Asthma ? Ear Infections

? Croup ? Strep Throat ? Eczema

Other Illnesses_____

_____

Medical Care Information

My Child's Physician is:

Name:_____
Address:_____
Telephone Number: _____
Number:_____

My Child's Dentist is:

Name:_____
Address:_____
Telephone

Authorization for Emergency Medical Care

In case of accident or illness requiring medical attention, the undersigned authorize's_____(child care provider) to call a health care provider or to take my child_____(child's name) to the nearest hospital or doctor; and it is understood that if possible, his services will be obtained. If neither parents nor preferred health care provider can be contacted, the child care provider is authorized to contact another health care provider. It is also understood that this agreement covers only those situations which, in the best judgment of the child care provider, are true emergencies.

The health care provider to call is:

Name:_____
Address:_____
Telephone Number:_____

My hospital preference is:

Name:_____
Address:_____
Telephone Number:_____

I agree to be responsible for the cost of such emergency medical care.

Parent(s)/ Guardian(s)_____Date_____
_____Date_____