

## Child Admission Agreement & Health Assessment

Name of Child \_\_\_\_\_ Enrollment Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Nickname \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle one) 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**

| 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<br>(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

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

**(See reverse side for required Health Assessment.)**

# Child Health Assessment

Please Write Clearly

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

### Check All That Apply:

Does your child have any known allergies or sensitivities to:

|             | No                       | Yes                      | If yes, please list: |
|-------------|--------------------------|--------------------------|----------------------|
| Medications | <input type="checkbox"/> | <input type="checkbox"/> | _____                |
| Foods       | <input type="checkbox"/> | <input type="checkbox"/> | _____                |
| Other       | <input type="checkbox"/> | <input type="checkbox"/> | _____                |

### Illnesses or Medical Conditions:

Does your child have any of the following:

|                    | No                       | Yes                      |                                  | No                       | Yes                      |
|--------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| Asthma             | <input type="checkbox"/> | <input type="checkbox"/> | Visual Impairment                | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes           | <input type="checkbox"/> | <input type="checkbox"/> | Developmental Delays             | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures           | <input type="checkbox"/> | <input type="checkbox"/> | Physical Impairment              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Problems     | <input type="checkbox"/> | <input type="checkbox"/> | Behavioral or Emotional Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Impairment | <input type="checkbox"/> | <input type="checkbox"/> | 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed and/or update: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Reviewed and/or update: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Reviewed and/or update: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_