Country Living Learning Center
Play, Learn and Grow Together

Child Health Form

Child's name_____ Age _____ DOB_____

Hospital of Preference

_____

_____

Chronic Medical Condition: _____

Does your child have a health care plan?_____ If yes, the health care plan must be provide on or before the first day the child is in care.

Is your child fully immunized? _____ ***Completed immunization records must be provided on or before the first day the child is in care.***

Allergies:

_____

_____

_____

Health History (Chronic or recurring)

Ear Infections _____ Diabetes_____ Heart disease/ defect _____
Convulsion/seizures _____Asthma _____ Nosebleeds _____ Measles _____
Mumps _____ Chicken Pox _____ Flu_____

Operations or serious injuries (dates)

_____

_____

Is the child on any medications? (Explain)

_____

_____

Physical limitations_____ Describe if yes _____

Dietary limitations _____ Describe if yes _____

Vision _____ Hearing _____

Are there any activities that you prefer that your child NOT participate in?

If so please list:

_____

_____

_____

Authorization of Emergency Medical Care

I hereby give my permission to CLLC to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____.

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is no possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of emergency transpiration, medical or surgical treatment.

Parent/Guardian signatures

_____ Date _____

_____ Date _____