

## Child Admission Agreement

Name of Child	Nickname	Birth Date month/day/year	Sex (check one)	Enrollment Date (check the box if no longer enrolled)
		__/__/__	F <input type="checkbox"/> M <input type="checkbox"/>	__/__/__ <input type="checkbox"/>
		__/__/__	F <input type="checkbox"/> M <input type="checkbox"/>	__/__/__ <input type="checkbox"/>
		__/__/__	F <input type="checkbox"/> M <input type="checkbox"/>	__/__/__ <input type="checkbox"/>

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 an emergency or a serious illness and the parents cannot be reached immediately, I hereby authorize the provider to obtain emergency medical care and/or provide emergency medical transportation for my child.

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Name 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: \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Name of Parent or Guardian Date

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

**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	<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 conditions?

	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 Name \_\_\_\_\_ 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 Name: _____
Reviewed and/or update: ____/____/____	_____
Reviewed and/or update: ____/____/____	_____

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