Child Health Report

Parent/Provider fill in this part.

Child's Name: (Last) (First)	Father's Name:
Date of Birth: (DD/MM/YYYY)	Mother's Name:
Home Phone:	Address:
Work Phone:	

I authorize the daycare staff and my child's physician to communicate directly about my child if needed to clarify information on this form.

PARENT'S SIGNATURE: ______________________________

Parents may write immunization dates. Physician should verify and complete all data.

Do Not Omit Any Information

☐ None	Health history and medical information pertinent to routine child care and diagnosis/treatment in emergency:
☐ None	Describe all medication and any special diet the child receives, along with the reason for the medication and special diet. All medication a child receives should be documented in the event the child requires emergency medical care. Attach additional sheets if necessary.
☐ None	List all the child's allergies (include medication, environmental and food allergies):
☐ None	List any health problems or special needs and recommended treatment/services. Attach additional sheets if necessary to describe the plan for care that should be followed for the child, including indication of special training required for staff, equipment and provision for emergencies.
☐ Yes ☐ No	In your assessment, is the child able to participate in daycare and does the child appear to be free from contagious or communicable diseases? If no, please explain your answer:

Note if the results of vision or hearing screenings were abnormal. If the screening was abnormal, provide the date the screening was completed and information about referrals, implications or actions recommended for the child care facility.		
	Vision (subjective until age 3)	
	Hearing (subjective until age 4)	

Record dates of immunizations below or attach a photocopy of the child's immunization record.

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
BCG						
POLIO						
PENTAVALENT						
PNEUMOCOCCAL						
MEASLES						
ROTAVIRUS						
VARICELLA						
MENINGOCOCCAL						
TYPHOID						
HIB						
HEP-A						
HEP-B						
MMR						
OTHER						

Physician's Name:	Signature of Physician:
Address:	
Phone:	License Number: Date Form Signed:

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