

# CHILD CARE: ENROLLMENT, HEALTH HISTORY, EMERGENCY CARE PLAN, IMMUNIZATION RECORD

## CHILD'S INFORMATION

<b>First Name:</b>	<b>MI:</b>	<b>Last Name:</b>	<b>Birthdate</b> (mm/dd/yyyy)	
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Home Phone:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<b>1<sup>st</sup> day of attendance:</b>	

**Family Information** All parents/guardians are permitted to visit during center hours & are allowed to pick up, unless there is a court order on record (provide copy).

<b>Relationship to Child:</b>	<b>Name:</b>	<b>Cell Phone:</b> ( ) ( )
<b>Home Address:</b>		<b>Home Phone:</b> ( ) ( )
<b>Name of Employer or where reachable while child is in care:</b>		
<b>Work Address</b> (Street, City, State, Zip):		<b>Work Phone:</b> ( ) ( )
<b>Relationship to Child:</b>	<b>Name:</b>	<b>Cell Phone:</b> ( ) ( )
<b>Home Address</b> (Street, City, State, Zip):		<b>Home Phone:</b> ( ) ( )
<b>Name of Employer or where reachable while child is in care:</b>		
<b>Work Address</b> (Street, City, State, Zip):		<b>Work Phone:</b> ( ) ( )

**EMERGENCY CONTACT**-Provide contact information to use when family cannot be reached. Is this person authorized to pick up your child?  Yes  No

<b>Relationship to Child:</b>	<b>Name:</b>	<b>Cell Phone:</b> ( ) ( )
<b>Home Address</b> (Street, City, State, Zip):		<b>Home Phone:</b> ( ) ( )
<b>Name of Employer or where reachable while child is in care:</b>		
<b>Work Address</b> (Street, City, State, Zip):		<b>Work Phone:</b> ( ) ( )

**ADDITIONAL PERSONS AUTHORIZED TO PICK UP CHILD**-Provide information requested for each person. If no one, write "None."

<b>Relationship to Child:</b>	<b>Name:</b>	<b>Phone:</b> ( ) ( )
<b>Location while child is in care</b> (Street, City, State, Zip):		<b>Alternate Phone:</b> ( ) ( )
<b>Relationship to Child:</b>	<b>Name:</b>	<b>Phone:</b> ( ) ( )
<b>Location while child is in care</b> (Street, City, State, Zip):		<b>Alternate Phone:</b> ( ) ( )
<b>Relation to child:</b>	<b>Name:</b>	<b>Phone:</b> ( ) ( )
<b>Location while child is in care</b> (Street, City, State, Zip):		<b>Alternate Phone:</b> ( ) ( )

## HEALTH HISTORY AND EMERGENCY CARE PLAN

<b>Physician:</b>	<b>Medical Facility:</b>	<b>Phone Number:</b>	
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

<b>Medical Conditions</b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy or Seizure Disorder <input type="checkbox"/> Emotional/Behavior disorder including ADD or ADHD
	<input type="checkbox"/> Cerebral Palsy/Motor Disorder <input type="checkbox"/> Gastrointestinal or feeding concerns including special diet & supplements
	<input type="checkbox"/> Other conditions that may require special care: _____
	<input type="checkbox"/> Allergies (food & non-food): _____
<input type="checkbox"/> <b>No specific medical conditions or known allergies</b>	

List: triggers, signs or symptoms, steps to follow when presented with a medical situation, staff that have received specialized training or instruction to assist your child, when to contact you if the symptoms fail to respond to treatment or any other additional information that would be helpful to know about your child. Attach additional page if needed. \_\_\_\_\_

**AUTHORIZATIONS** -By checking each box in this section, I am giving consent, permission or acknowledging understanding of each area listed.

- I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- I give permission for my child to participate in both transported and walking field trips and other activities during operation hours.
- I have been informed that there are no pets in the center & understand that I will be informed in writing prior to a pet's addition.
- I have had an opportunity to review the policies of this child care center and the Wisconsin Rules for Licensed Child Care Centers.

## PERMISSION TO APPLY SUNSCREEN &/OR INSECT REPELLANT

<input type="checkbox"/> I give my permission for my child to apply sunscreen or to have an adult assist in the application if developmentally appropriate to receive assistance.
<b>Name Brand of Sun Screen I am providing:</b> _____ <b>SPF Strength:</b> _____ <b>Times to apply:</b> _____
<input type="checkbox"/> I give my permission for my child to apply insect repellent or to have an adult assist in the application if developmentally appropriate to receive assistance.
<b>Name Brand of Bug Spray I am providing:</b> _____ <input type="checkbox"/> With Deet or <input type="checkbox"/> Without Deet <b>Times to apply:</b> _____

**DAY CARE IMMUNIZATION RECORD** - State law requires all children in day care centers to present evidence of immunization against certain disease. This requirement can only be waived for health, religious, or personal convictions if a properly signed "Immunization Waiver" is completed and returned with this form, prior to enrollment. Waivers are available at the front desk.

The following immunizations are required at entrance to day care.	1st Dose Month/Day/Year	2nd Dose Month/Day/Year	3rd Dose Month/Day/Year	4th Dose Month/Day/Year	5th Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP or DT)					
Polio					
Hib (Haemophilus Influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella Vaccine (Required if the child has not had chickenpox.)				<input type="checkbox"/> My child had chickenpox in _____(year).	

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_