**Child's Name** ______________________________________________
(last) (first) (middle)

# Health Form

***This form must be returned in order to register your child. Please inform us of any changes in information as they occur.***

## CHILD'S INFORMATION

Name: ______________________________________________
(first) (middle) (last)

Birthdate: ____/____/____ Grade ______ Gender: ☐ male ☐ female Race: ______________

School attending: ______________________ Site attending: ______________________

## HEALTH INFORMATION

**IMPORTANT: Please notify YMCA Childcare if your child's information changes. Please give approximate dates:**

| **Conditions** | **Allergies** | **Diseases** |
|---|---|---|
| ☐ Frequent Ear Conditions | ☐ Hay Fever | ☐ Measles ______ |
| ☐ Heart Defect | ☐ Poison Ivy | ☐ German Measles ______ |
| ☐ Convulsions | ☐ Insect Stings | ☐ Mumps ______ |
| ☐ Diabetes | ☐ Penicillin | ☐ Chicken Pox ______ |
| ☐ Bleeding Disorders | ☐ Peanuts/nuts | ☐ Asthma ______ |
| ☐ Other | ☐ Other | ☐ Other ______ |

Operations or serious injuries (please list dates)______________________

Chronic or recurring illness ______________________

Is your child taking any medication? ______ Name of Medication ______________________

Dose ______________ Special instructions ______________________

Any specific activities to be encouraged? ______________ Restricted? ______________

Special needs (health, physical, psychological, or educational) for Childcare staff awareness: ______________
______________________________________________

**IMPORTANT: Please notify YMCA Childcare if your child is exposed to any communicable diseases.**

Family Physician ______________________ Phone ______________

Dentist/Orthodontist ______________________ Phone ______________

Medical Insurance Carrier ______________________ Policy # ______________

## IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

This health history is correct to the best of my knowledge and the child herein described has permission to engage in all prescribed activities except as noted. I hereby give permission to the physician selected by the director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above.

______________________ ______________________ ______________
Parent/ Guardian Signature Printed Name Date

*TO BE COMPLETED BY A HEALTH CARE PROVIDER*

# Immunization Record

**This form must be completed to register.**
**This form will be updated annually.**

Child's full name ____________________________________________ Birthdate_______/_______/_______

Parent/Guardian name_________________________________________Phone ________________________

School attending ________________________________ Site attending _______________________________

| **Hep B** | | | | | |
|---|---|---|---|---|---|
| **DtaP/ DTP/ Td** | | | | | |
| **Hib** | | | | | |
| **MMR** | | | | | |
| **IPV** | | | | | |
| **Varicella (Chicken Pox)** | | | | | |
| **PCV / Prevanar** | | | | | |

Date of last Tetanus shot ____________________________________________________________________

Child has documented history of Chicken Pox? _____No _____Yes If yes, age ________________________

**Parent Comments:** (Please indicate religious objections, if any.) ____________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Health Care Provider Comments:** (Please list immunizations excluded for medical purposes.) ____________
______________________________________________________________________________________
______________________________________________________________________________________

**Please check the appropriate response:**

_____ Child has received age-appropriate immunizations.

_____ Child is currently in the process of receiving age-appropriate immunizations.

Signed ____________________________________________________ Date_________________________
Health Care Provider's Signature

Printed Name and Title ___________________________________________________________________