

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

- Frequent Ear Conditions
- Heart Defect
- Convulsions
- Diabetes
- Bleeding Disorders
- Other _____

Allergies

- Hay Fever
- Poison Ivy
- Insect Stings
- Penicillin
- Peanuts/nuts
- Other _____

Diseases

- Measles _____
- German Measles _____
- Mumps _____
- Chicken Pox _____
- Asthma _____
- 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 prior to your child's first day of attendance.
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 _____