CONGREGATION ALBERT
EARLY CHILDHOOD CENTER
CONFIDENTIAL STUDENT HEALTH INFORMATION

Child's Name_____ Date of Birth_____Sex_____

Address_____ Home Phone_____

Parent Name_____ Work Phone_____

Parent Work Address_____ Cell Phone_____

Parent Name_____ Work Phone_____

Parent Work Address_____ Cell Phone_____

Is your child's health excellent, fair, poor? _____ Weight_____Height_____

Does your child have any allergies or medical conditions: no… yes…….if yes please state: _____

_____

EMERGENCY CONTACTS: Indicate in order of preference at least 2 people other than parents to be contacted in case of emergency.

Telephone	Name	Relationship	Address

Please attach a copy of your child's official immunization record.
(This area does not need to be filled in with a copy of your child's immunization record for his/her confidential file)

HISTORY

Disease	**Date**
Whooping Cough	_____
Rubella	_____
Chicken Pox	_____
Mumps	_____
Measles	_____

IMMUNIZATIONS

Required	**1st**	**2nd**	**3rd**	**Last Booster**
DPT or DT				
Polio				
Measles				
Rubella				
Mumps				
HIB				
Tb Skin Test (Neg/Pos)				
Chicken Pox				
Hepatitis B				

List any physical, mental, emotional disorders and any serious accidents or surgery your child has had. Indicate year of occurrence_____

_____

Is your child currently taking any prescription medication? If so, please specify name, dosage and schedule:

_____

_____

_____

Has your child ever had a dental check-up? _____Date_____Any treatment necessary? _____ (Yes/No) Explain_____

Has your child ever had a professional eye examination? _____ Date_____Any treatment necessary? _____ (Yes/No) Explain_____

Has your child ever had a professional hearing test? _____ Date_____Any treatment necessary? _____ (Yes/No) Explain_____

Resources are available for Pediatrician, Pediatric Audiologist, Ophthalmologist or Dentist

AUTHORIZATIONS FOR EMERGENCY MEDICAL CARE AND TRANSPORTATION

EMERGENCY MEDICAL CARE: _____
Doctor Address Phone

HOSPITAL: _____
Address Phone

MEDICAL RECORD NUMBER/IDENTIFICATION NUMBER: _____

I hereby authorize Congregation Albert Early Childhood Center to take my child to the above-named physician or facility for medical treatment in the event of an emergency in which neither parent can be reached.

_____ _____
Signature Date

I hereby authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above-named physician cannot respond.

_____ _____
Signature Date

Date of Enrollment_____ Date of Disenrollment_____

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