School-Age Child Health Form/Parent Statement of Health

Parent/Guardian please complete pages 1 and 2.

Child's name	Child's birthdate	Name of school Grade ____ School Telephone #

Parent/Guardian name #1	Parent/Guardian name #2

Child home address #1	Telephone # 1
Child home address #2	Telephone # 2

Where parent/guardian #1 works	Work address	Telephone # Work # Cellular # Home email Work email
Where parent/guardian #2 works	Work address	Telephone # Work # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian. YES NO

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: ____ **Date** ______________

Alternate emergency contact person's name:_________________________ **Phone #** _________________
Relationship to child:_________________________ **Cellular #** _________________

Child's **Doctor's** name ☐ Child does not have doctor	Doctor telephone #1	**Hospital of choice** Phone #____________________
Doctor's address	After hours telephone #	Does your child have health insurance? ☐ YES ☐NO Company ______________ **ID#**
Child's **Dentist's** name ☐ Child does not have dentist	Dentist telephone #1	Does your child have dental insurance? ☐ YES ☐NO Company ______________ **ID#**
Dentist's address	After hours telephone #	☐ **HELP us find a family doctor or dentist** ☐ **HELP us find health or dental insurance**
Other health care/mental health specialist name **Type of specialty**	Telephone #	

Child Name: ______________

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Parent/Guardian complete this page

Child name: ______________________________

Please use an **X** in the box ☐ to statements that apply to your child.

Date of child's last physical exam: ___________
Date of last dental appointment: _____________

Growth
☐ I am concerned about child's growth.
Appetite
☐ I am concerned about child's eating habits.
Rest
☐ My child needs to rest after school.
Illness/Surgery/Injury
☐ My child had a serious illness, surgery, or injury.
Please describe:

Physical Activity - My child
☐ Must restrict physical activity or needs special equipment to be active. Please describe:

Play with friends - My child
☐ Plays well in groups with other children.
☐ Will play only with one or two other children.
☐ Prefers to play alone.
☐ Fights with other children.
☐ I am concerned about my child's play activity with other children.

School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

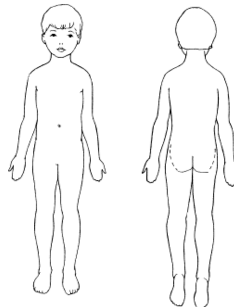
☐ **Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.). List allergies:

☐ **Special Needs Care Plan** –My child has a special needs care plan (IEP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

Body Health - My child has problems with

☐ Skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



☐ Eyes/vision, glasses or contact lenses
☐ Ears/hearing, hearing assistive aides or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or wetting accidents
☐ Hard stools, constipation, diarrhea, watery stools
☐ Bones, muscles, movement, pain when moving
☐ Mobility, child uses assistive equipment
☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Females – difficult monthly periods
☐ Other special needs. Please describe:

☐ **Medication**[1] - My child takes medication.

Medication Name	Time Given	Reason for giving medication

Child has Epipen, inhaler, or other emergency medication.
☐ Yes ☐ No

Parent Signature: (required)	**Date:**

[1] Parents: Please review the child care program's policies about the use of medication at child care.