# HEALTH HISTORY FORM

Child's Name:________________________________ Child's Birthdate:______________________

Child Lives With: _____ Mother _____ Father _____ Guardian, explain:____________________

Mother's Name or Guardian:____________________ Address:_____________________________

Mother's Home Phone:________________________ Mother's Work Phone:________________

Mother's Work:____________________Mother's Work Address:__________________________

Father's Name or Guardian:____________________ Address:____________________________

Father's Home Phone:________________________ Father's Work Phone:_________________

Father's Work:___________________ Father's Work Address:___________________________

Special Information (Legal restrictions, foster home placement, etc.):_______________________

_________________________________________________________________________________

In Case of Emergency, people to contact if parent or guardian is not available:

1st Choice:_______________________ Phone:_____________________ Relationship:_________

2nd Choice:______________________ Phone:_____________________ Relationship:_________

Physician:_______________________ Phone:_____________________ Relationship:_________

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I/We, the undersigned, am/are the parent(s) or persons having legal custody of the above named minor. I/We now am/are enttitled to full and complete custody of said minor child.

I/We hereby authorize Merit Enrichment in whose care the above named child has been entrusted by me/us, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general and special supervision and upon the advice of a physician and surgeon licensed under the provisions of the state medical laws and hospital care to be rendered to said minor by a dentist licensed under the state dental laws.

We will assume financial responsibility for medical costs.

Parent's/Guardian's Signature____________________________________ Date________________

LIABILITY INSURANCE

Parent/Guardian sign below:

I have been informed that Merit Enrichment DOES carry liability insurance, as required by the Health and Safety Code of our state.

Parent's/Guardian's Signature____________________________________ Date________________

I have received copies of the following literature required by Family Day Care Licensing in our state: Parents' Rights, Child Sexual Abuse, and Family Day Care for Children.

Parent's/Guardian's Signature____________________________________ Date________________

| Has your child had: | | |
|---|---|---|
| Ilness: | Yes | No |
| Chicken Pox | | |
| Diptheria | | |
| Measles | | |
| Meningitis | | |
| Mumps | | |
| Pneumonia | | |
| Rheumatism | | |
| Rubella | | |
| Scarlet Fever | | |
| Strep Infections | | |
| Whooping Cough | | |
| Other: | | |
| | | |
| Allergies: | | |
| Eczema | | |
| Asthma | | |
| Diabetes | | |
| Hypoglycemia | | |
| Hyperactivity | | |
| Other: | | |
| Other: | | |

## SPECIAL DIET

What type of diet is your child on?

What foods is your child allergic to?

Please give instructions:

## AUTHORIZATION TO LEAVE CARE

The following person(s) is authorized to pick up my child:

Name:_______________________________________

Relationship:____________ Phone:________

Name:_______________________________________

Relationship:____________Phone:________

Name:_______________________________________

Relationship:___________ Phone:________

________________________ ______________

Parent's/Guardian's Signature Date

| IMMUNIZATION SUMMARY | | | | | | | | Exempt Medical Religious |
|---|---|---|---|---|---|---|---|---|
| Child's Age By: | Immunization Needed | Date of Dose | | | | | | |
| | (Circle Immunization) | 1st | 2nd | 3rd | 4th | 5th | 6th | |
| 12 mos. | 3 DPT or TD | | | | | | | |
| 12 mos. | 2 Polios | | | | | | | |
| 15 mos. | MMR | | | | | | | |
| 15-18 ms. | IDPT or TD | | | | | | | |
| 15-18 ms. | 1 Polio | | | | | | | |
| 18-59 ms. | HIB | | | | | | | |
| 4-6 yrs. | 1 Polio | | | | | | | |
| 4-6 yrs. | 1 DPT or TD | | | | | | | |
| 14-16 yrs. | 1 DPT or TD | | | | | | | |

## TUBERCULIN TEST

______ Yes Test Date:________

______ No

## FIELD TRIP AUTHORIZATION

I give Merit Academy and the adult assistant caregivers permission to take the above named child for field trips as part of the family day care program. Some of these trips will be by car and seat belts and/or car seats shall be used.

Parent/Guardian's Signature___________________________Date_________