Lincoln-Lancaster County Health Department

Child's Record

Child's Information

Name:	Sex: ☐Male ☐Female		Birthdate:	Enrollment Date:
Address:		City:		

Parent or Guardian Information

FATHER (or Guardian):		Employer:
Address: ☐ same as above		Address:
City:		City:
Home Phone:	Cell Phone:	Phone:

MOTHER (or Guardian):		Employer:
Address: ☐ same as above		Address:
City:		City:
Home Phone:	Cell Phone:	Phone:

Person(s) to Whom the child may be released: (If no one, write "none")

Name:		Name:	
Address: City:		Address: City:	
Home Phone:	Cell Phone:	Home Phone:	Cell Phone:

Emergency Contact(s) for when the parent cannot be reached: (at least one name must be given)

Name:		Name:	
Address: City:		Address: City:	
Home Phone:	Cell Phone:	Home Phone:	Cell Phone:

Transportation Permission:

I hereby give _____*(facility)* permission to transport or arrange for transportation of _____*(child's name)*. I understand staff will insure that my child is placed in the appropriate safety restraint as indicated by Nebraska law at all times the vehicle is in motion.

_____ _____

Signature of Parent/Guardian *Date*

Consent to Contact Physician in the event of an emergency:

In the event I cannot be reached, I hereby give my consent for _____*(facility)* to contact my child's doctor and, if necessary, take my child to his/her clinic or nearest hospital.

_____ _____

Signature of Parent/Guardian *Date*

Child's Health History

Name of Doctor:	Clinic Name:	
Address: City:		Phone:
Were there any significant problems during pregnancy or birth? ☐No ☐Yes, Please explain:		
Has your child had surgery or been hospitalized? ☐No ☐Yes, Please explain:		
Date last seen by a healthcare provider (for reasons other than immunizations):		

Medication

Does your child take medication on a regular basis? ☐No ☐Yes Reason:			
Name of medication(s), dosage and when taken:			
Has your child had any of the following?		***Age of child or date of incident:***	
Asthma	☐No	☐Yes, describe:	*If your child has asthma, please request & complete an Asthma Action Plan.*
Other breathing problems	☐No	☐Yes, describe:	
Seizures or other neurological problems	☐No	☐Yes, describe:	
Heart or other cardiovascular problems	☐No	☐Yes, describe:	
Bladder or urinary tract problems	☐No	☐Yes, describe:	
Bowel or other GI problems	☐No	☐Yes, describe:	
Bone or joint problems	☐No	☐Yes, describe:	
Eczema or skin problems	☐No	☐Yes, describe:	
Frequent ear infections or tubes	☐No	☐Yes, describe:	
Other ear, nose or throat problems	☐No	☐Yes, describe:	
Chicken Pox or vaccination for such	☐No	☐Yes, describe:	
Diabetes or other endocrine problems	☐No	☐Yes, describe:	
Injury or abuse	☐No	☐Yes, describe:	
Car sickness	☐No	☐Yes, describe:	
Other describe:			

Medication Competency Statement

I have determined _____*(provider/director)* competent to give or apply medication to my child.

_____ _____

Signature of Parent/Guardian *Date*

Nutrition History

Is there any food or drink that your child should not eat for cultural, religious, personal reasons or medical reasons ***other than allergies***? (Note: use the allergy chart to list any allergies to food or drink)

☐ **Yes, list below** ☐ ***No, skip to next question***

Name of food/drink:	☐Cultural	☐Religious	☐Personal	☐Medical/describe:	
	☐Cultural	☐Religious	☐Personal	☐Medical/describe:	
	☐Cultural	☐Religious	☐Personal	☐Medical/describe:	
	☐Cultural	☐Religious	☐Personal	☐Medical/describe:	
Does your child have any problems with chewing or swallowing?	☐No	☐Yes, Please describe:			
Check the box if you have concerns about your child's	☐Eating habits	☐Height	☐Weight		
Please describe:					

Allergy History

Does your child have allergies or reactions (including intolerance to food, medicine, insects, animals or other substances?

☐ ***Yes, please complete chart below*** ☐ ***No – Skip to Dental History***

Allergy Chart *Note: If your child has a food or milk allergy, we must have written documentation of the allergy from the doctor. For milk allergies, the doctor must also name a substitute for the milk.*

Do you keep epinephrine (epi-pen) available at home for your child's allergy? ☐Yes ☐No

List each allergy or food separately	***Briefly describe child's reaction and/or check symptoms***	***Potential Severe Reaction****	***Doctor/Date of Diagnosis***
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	
	☐Hives ☐Wheezing ☐Runny nose ☐Shortness of breath	☐Yes ☐No	

**** If the allergy has the potential to be severe, the child's health care provider should complete a medical statement and an Allergy Action Plan should be completed and on file. Please request and complete a "Food Allergy Action Plan" form (available from child care personnel).***

Additional information about allergy:

Dental History

Name of dentist:	Date last seen by dentist:	City/State:	Phone number:

How would you rate your child's dental health? ☐ Very good ☐ Somewhat good ☐ Fair ☐ Somewhat bad ☐ Very bad

Has your child ever had an injury to the teeth or gums? ☐ ☐ Yes, please explain:

Has your child complained about pain in the teeth or gums? ☐ No ☐ Yes

Is there fluoride in the water at your home, or is your child taking a prescribed fluoride supplement? ☐ No ☐ Yes

Parental Concerns

Do you have any concerns about your child's vision?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's hearing?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's speech?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's behavior?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's development?	☐ No	☐ Yes, Please describe:
Do you have any other concerns about your child?	☐ No	☐ Yes, Please describe:

Additional information regarding concerns:

Certificate of Immunizations

VACCINE	TYPE OF VACCINE	Dose	Normal Schedule	Date Given Mo.	Day	Yr.	DOCTOR OR CLINIC ADMINISTERING
Polio		1	2 mo.				
OPV or		2	4 mo.				
IPV		3	6-18 mo.				
		4	4-6 yrs.				
DTP/DT/DTaP		1	2 mo.				
Diphtheria		2	4 mo.				
Tetanus		3	6 mo.				
Pertussis		4	15-18 mo.				
		5	4-6 yrs.				
Tdap		1	11-18 yrs.				
Td/Tetanus							
and Diphtheria							
Hib		1	2 mo.				
Haemophilus		2	4 mo.				
influenzae b		3	6 mo.				
		4	12-15 mo.				
M-M-R		1	12-15 mo.				
		2					
Hepatitis A		1					
		2					
Hepatitis B		1					
		2					
		3					
Varicella		1	12-18 mo.				
Chickenpox		2					
date of disease							
Meningococcal		1					
Conjugate							
PCV		1	2 mo.				
Pneumococcal		2	4 mo.				
Conjugate		3	6 mo.				
		4	12-15 mo.				
		1	2 mo.				
Rotavirus		2	4 mo.				
		3	6 mo.				

I have received a copy of the Parent Handbook and I agree to abide by the child care policies in it. Furthermore, the information I have provided on this form is correct to the best of my knowledge.

_____ _____

Signature of Parent/Guardian *Date*