



Olive Site (415) 892-4111

P.O. Box 2037 • Novato, CA 94948

Lynwood Site (415) 892-6223

Medical Information Sheet

Child's Name (Last) _____ (First) _____ Birth Date _____
School Attending _____ Grade _____
Parents/Guardians _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Mother's Employer _____ Work Phone _____
Occupation _____ Drivers License # _____
Father's Employer _____ Work Phone _____
Occupation _____ Drivers License # _____
E-mail (Mother) _____ E-mail (Father) _____
Cell Phone (Mother) _____ Cell Phone (Father) _____

In an Emergency, notify the following (every effort will be made to notify parent(s) first:
Name _____ Home Phone _____
Work Phone _____ Relationship _____
Child's Doctor _____ Phone Number _____
Child's Dentist _____ Phone Number _____
Health Plan _____ Medical Ins. Number _____

Persons Authorized to take Child from Center:
Name _____ Phone Number _____
Name _____ Phone Number _____
Name _____ Phone Number _____

Relevant Information:
Siblings at Home _____
Any specific activities your child should be restricted from? ___ Yes ___ No (if yes, specify on back)
Does your child have any allergies? ___ Yes ___ No (if yes, specify on back)

Child's Hobbies/Interests _____
Are both Parents living at home? ___ Yes ___ No (if no, please complete the following)
Other Parent's Name _____ May they take the child from the Center? ___ Yes ___ No
Address _____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____

IN CASE OF MEDICAL EMERGENCY, I understand that every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give permission to the physician listed above to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child. I also give permission for my child to participate in the Child Care program at LYNWOOD and/or OLIVE Center. In case of injury to my child, I waive all claims against QUALITY CARE FOR KIDS and its Teachers and Employees.

Signature or Parent or Guardian Date

(Please fill out reverse side)

Medical Information Sheet continued

Child's Name (Last) _____ (First) _____

Health History (Check all that apply- Giving approximate dates)

Frequent Colds	_____	Asthma	_____
Hay Fever	_____	Bronchitis	_____
Ear Infection	_____	Stomach Upsets	_____
Fainting	_____	Kidney Trouble	_____
Operations / Serious Injuries	_____	Chicken Pox	_____
Convulsions	_____	German Measles	_____
Measles	_____	Rheumatic Fever	_____
Mumps	_____	Whooping Cough	_____
Diabetes	_____	Other	_____
Frequent Sore Throats	_____	Other	_____

ALLERGIC REACTIONS: Bee Sting _____ Penicillin _____ Other Drugs _____

FOOD RESTRICTIONS OR ALLERGIES _____

* Details of above or additional information _____

If your child has any physical disorders, etc. please note: _____

Specific activities to be restricted _____

Any suggestions from Parent's _____

Any suggestions from your Child's Doctor _____

Anything special about your child that would be helpful to us during your child's attendance _____