QUALITY CARE FOR KIDS

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 ____

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* Details of above or additional information ____

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

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Specific activities to be restricted ____

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Any suggestions from Parent's ____

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Any suggestions from your Child's Doctor ____

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

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