Child and Family Information

Child's Information

Child's Full Name: ________________________________
Age of Child: ___________________ Birthdate of Child: ________________________
Child's Nickname: ________________________________

Parent's/Family Information

Parent(s) Name(s): ________________________________
Parent’s Location During Caregiving: ________________________________
Location Telephone Number: ________________________________
Cell Telephone Number: ________________________________
Work Telephone Number: ________________________________

Information about My Child

My Child’s favorite toys: ________________________________
Unique words/phrases my child uses: ________________________________
Foods my child likes or is permitted and mealtimes: ________________________________
Foods my child does not like or cannot eat: ________________________________
TV shows my child can watch: ________________________________
My child’s favorite activities: ________________________________
Activities I do not wish my child to do: ________________________________
My child’s sleep habits and nap/bedtimes: ________________________________
My child’s fears are: ________________________________
Guidelines I use in letting my child use the computer or other similar devices: ________________________________

Other information that will help you provide loving, good care: ________________________________

Health Information about My Child

My child has allergies:  
☐ Yes  ☐ No  If yes, please describe.  

Allergy: ________________________________
Reactions: ________________________________

My child has asthma:  
☐ Yes  ☐ No  If yes, please describe condition and medical treatment.  

Next Page
My child has a health condition:  

☐ Yes  ☐ No  

If yes, please describe condition and how it is treated.

My child takes medicine currently, either prescribed or over-the-counter:  

☐ Yes  ☐ No  

If yes, please describe.

<table>
<thead>
<tr>
<th>Name</th>
<th>Purpose</th>
<th>Dose/Time</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Other relevant health information is:

Emergency Information

If I cannot be reached, contact:

Name: ____________________________
relationship: ____________________________
Location: ____________________________
Work Telephone Number: ____________________________
Cell Telephone Number: ____________________________
Other Telephone Number: ____________________________

A neighbor who can be contacted in an emergency:

Name: ____________________________
Address: ____________________________
Home Telephone Number: ____________________________
Cell Telephone Number: ____________________________
Other Telephone Number: ____________________________

Our 911 address is ____________________________
Direction to our home is:
### Medical/Professional Emergency Personnel

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The name of my child’s <strong>physician:</strong></td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>The name of my child’s <strong>dentist:</strong></td>
<td>Telephone Number:</td>
</tr>
<tr>
<td><strong>Other health care provider:</strong></td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>(Field of Practice):</td>
<td></td>
</tr>
<tr>
<td>Preferred <strong>hospital</strong></td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Address of hospital</td>
<td></td>
</tr>
<tr>
<td><strong>Fire department</strong></td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Preferred <strong>ambulance</strong></td>
<td>Telephone Number:</td>
</tr>
</tbody>
</table>

### Other important numbers

<table>
<thead>
<tr>
<th>Organization</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poison Control</td>
<td></td>
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</tbody>
</table>

### My child’s health insurance information

<table>
<thead>
<tr>
<th>Provider:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured’s Name and ID#:</td>
<td></td>
</tr>
<tr>
<td>Group ID#:</td>
<td>Policy ID#:</td>
</tr>
</tbody>
</table>
Emergency and Medical Treatment Authorization

Authorization

, has permission to take the following actions that I have checked yes.

1. To seek EMERGENCY medical, dental or surgical treatment for my child while I am not present.
   - Yes
   - No

2. To transport my child in a private automobile in order to seek EMERGENCY medical, dental or surgical treatment.
   - Yes
   - No

3. To transport my child in an emergency vehicle in order to seek EMERGENCY medical, dental, or surgical treatment.
   - Yes
   - No

4. To transport my child for any reason in a private automobile.
   - Yes
   - No

5. Other:
   - Yes
   - No

Signature of Parent or Legal Guardian: _____________________________________________________
Date of Release: ____________

Signature of Parent or Legal Guardian: _____________________________________________________
Date of Release: ____________

Emergency Treatment Release

I give my permission for a licensed physician, dentist, emergency medical personnel, or hospital to provide emergency medical service to my child, at the request of the person bearing this consent form.

Child’s Name: ________________________________________________________________________

I agree to pay any cost and fees associated with the emergency treatment as secured under this authorization of consent form.

Signature of Parent or Legal Guardian: _____________________________________________________
Date of Release: ____________

Signature of Parent or Legal Guardian: _____________________________________________________
Date of Release: ____________
Permission To Give Medication
(Is completed by parent when reserving care for an ill child)

__________________________ has my permission to give _______________________
(caregiver’s full name) (child’s full name)
the following medications.

Note: If prescribed medication, the child’s name and doses of the medication must be on the medicine bottle. All
medications, prescribed or over-the-counter, must be in original container.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Amount/Dosage</th>
<th>Time(s) to be given</th>
<th>Date to be given</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
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Ordered by
- Parent
- Physician
- Other

Medication To Be Given

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Ordered by
- Parent
- Physician
- Other

Additional Instructions:


Parent/Guardian Signature: ________________________________

Date: ____________________
Child Care Incident Summary
(Completed by provider if an incident occurs)
If more space is needed, complete and attach a separate page to this form.

Child’s Name: __________________________________________

Date: __________________________________________

Time: __________________________________________

Description of incident (the “Who, What, Where, When, How and Why”) of the incident. Include the names of those present.

What steps were taken to care for the child?

Who was contacted, such as the parent, the emergency contact, emergency medical personnel, or medical provider?

Parent’s Response:

Caregiver’s Signature: __________________________________________

Date: __________________________________________

Parent’s Signature: __________________________________________

Date: __________________________________________

The following resource was used in the creation of and is acknowledged for the provision of the information found on this form – Iowa Family Child Care Handbook, 6th Edition, Iowa State University Extension, 1999
Description of Mild Illness
(Is completed by parent when reserving care for an ill child)

Child’s Information
Child’s Full Name: _________________________________
Birthdate of Child: _________________________________

<table>
<thead>
<tr>
<th>Current Symptoms</th>
<th>Yes</th>
<th>No</th>
<th>Describe, if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draining from nose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draining from eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draining from ears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draining from sores</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
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<td></td>
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<tr>
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</table>

Last temperature taken: the time ___________ and the degrees __________________________

Is your child’s temperature the same, rising or decreasing? __________________________

Has your child seen a doctor, and if so, the doctor’s orders?

__________________________________________________________________________

Has your child been exposed to a contagious disease recently, and if so, what?

__________________________________________________________________________

Other Information:

__________________________________________________________________________