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THE UNIVERSITY OF IOWA

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	Reaction
_____	_____
_____	_____

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

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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.

Name	Purpose	Dose/Time

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:

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Medical/Professional Emergency Personnel

The name of my child's **physician**: _____ Telephone Number: _____

The name of my child's **dentist**: _____ Telephone Number: _____

Other health care provider: _____

(Field of Practice): _____ Telephone Number: _____

Preferred **hospital** _____ Telephone Number: _____

Address of hospital _____

Fire department _____ Telephone Number: _____

Preferred **ambulance** _____ Telephone Number: _____

Other important numbers

Organization	Telephone Number
Poison Control	_____
_____	_____
_____	_____

My child's health insurance information

Provider: _____

Insured's Name and ID#: _____

Group ID#: _____ Policy ID# _____

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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: _____

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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.

Medication To Be Given

Medication _____

Amount/Dosage _____

Time(s) to be given _____

Date to be given _____

Other _____

Ordered by ☐ Parent ☐ Physician ☐ Other

Medication To Be Given

Medication _____

Amount/Dosage _____

Time(s) to be given _____

Date to be given _____

Other _____

Ordered by ☐ Parent ☐ Physician ☐ Other

Medication To Be Given

Medication _____

Amount/Dosage _____

Time(s) to be given _____

Date to be given _____

Other _____

Ordered by ☐ Parent ☐ Physician ☐ Other

Additional Instructions:

Parent/Guardian Signature:_____

Date: _____

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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

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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: _____

Current Symptoms

	Yes	No	Describe, if applicable
Congestion	○	○	_____
Cough	○	○	_____
Fever	○	○	_____
Diarrhea	○	○	_____
Sore Throat	○	○	_____
Vomiting	○	○	_____
Draining from nose	○	○	_____
Draining from eyes	○	○	_____
Draining from ears	○	○	_____
Draining from sores	○	○	_____
Nausea	○	○	_____
Rash	○	○	_____
Other:	○	○	_____
Other:	○	○	_____
Other:	○	○	_____

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: