



**MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES,  
INCLUDING PROVIDER'S OWN CHILDREN**

**Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.**

Child's First Day in Child Care \_\_\_\_\_ Name of Child Care Facility Learn & Grow Child Care Center

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
First Last MM/DD/YYYY M/F

**Parent/Guardian Information**

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Name \_\_\_\_\_ Name \_\_\_\_\_  
Home Address \_\_\_\_\_ Home Address \_\_\_\_\_  
Street City Zip Code Street City Zip Code  
Home Phone Number \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
Work Address \_\_\_\_\_ Work Address \_\_\_\_\_  
Street City Zip Code Street City Zip Code  
Work Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
Cell Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Best way to contact \_\_\_\_\_ Best way to contact \_\_\_\_\_

Names and ages of children in family \_\_\_\_\_

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary. \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Hospital Preference (for emergencies) \_\_\_\_\_

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider?  No  Yes, as follows:

Does your child have any of the following conditions (yes or no)? If yes, provide information on Authorization for Emergency Medical Care form CCL. 010.

Allergies  Frequent sore throats/colds  Ear Aches  
 Asthma  Speech, Visual, Hearing  Diabetes  
 Epilepsy/Seizures  Other \_\_\_\_\_

If yes answered to any above, please provide additional information \_\_\_\_\_

Have there been major changes at home that might affect your child in care?  No  Yes, as follows:

Please provide additional information or special instructions that will help the person caring for your child. \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_