

Health Information Form

Please ensure all information is current and filled out completely.

Program Name: _____

Child's Name: _____ Preferred: _____
(Surname) (Given) (Middle)

Address: _____

Phone#: _____

Sex: M ___ F ___ Birth Date: _____

1st Language _____

Parent/Guardian Information:

Name: _____

Name: _____

Place of work: _____

Place of Work: _____

Phone Number: _____

Phone Number: _____

Hours of work: _____

Hours of Work: _____

Persons other than parent who will be calling or picking up your child:

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Alternate person to call in case of emergency:

Name: _____ Relationship to Child: _____ Phone: _____

Medical Information:

Doctor: _____

Phone: _____

Care Card# _____

Date effective: _____

Dentist: _____

Phone: _____

If child has any known health problems, please indicate what they are: _____

I hereby give my consent for a staff member to call an ambulance for my child in the case of accident or illness, if I cannot immediately be reached.

Parent's Signature _____

Date _____