Children and Families of Iowa
Child Care Program

Child Health Information

Child's Name_____ Date of Birth_____

Parent's Name_____

Address_____ City/State/Zip_____

Telephone (home)_____ (work)_____ (cell)_____

Place of Employment_____

Doctor's Name_____ Telephone_____

Doctor's Address_____

Preferred hospital_____

Dentist's Name_____ Telephone_____

In case of emergency and parent cannot be reached, please contact:

1.Name_____ Telephone_____

2.Name_____ Telephone_____

Please check the appropriate box.

Has your child had any of the following?	**Yes**	**No**	
Measels (3 day)	O	O	
Measels (german)	O	O	
Mumps	O	O	
Whooping Cough	O	O	
Has your child ever been hospitalized?	O	O	If yes, explain_____
Any operations?	O	O	If yes, explain_____
Allergies (medication, food?)	O	O	If yes, explain_____
Diabetes in the family?	O	O	
Convulsions?	O	O	
Asthma?	O	O	**If yes, a Health Action Plan is required.**
Digestive Problems?	O	O	**If yes, a Health Action Plan is required.**
Heart trouble?	O	O	**If yes, a Heath Action Plan is required.**

***A Health Action Plan may be required for any illness, at the discretion of the Center.**

Other important health information_____

_____ _____

Parent/Guardian Signature Date