Health Statement

Child's Name:_____Birth Date:_____
Date Last Exam:_____
Status of Child's Health:_____
Any Known Allergies: _____
_____
Any Known Conditions Under Treatment:_____

On occasion there may be a need for the following over the counter medications to be administered. However these forms of medications may not be administered without prior authorization from the child's physician. Upon initialing the following forms of medication, the above named child will receive treatment as needed.

Diaper Rash Cream/Ointment:_____ _____
Specify Initial

Powder:_____ _____
Specify Initial

Teething Medications:_____ _____
Specify Initial

Sunscreen:_____ _____
Specify Initial

Child is capable of adjusting to indoor and outdoor programs of the learning center. YES NO

Physician/Clinic's Stamp:

Physician's Signature:_____

Office Phone Number (702)_____-_____

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