

HEALTH RECORD FOR CHILDREN IN PRESCHOOL

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM: Merkaz Shiurei Torah / Yiddishe Otzros

CHILD'S LAST NAME _____ FIRST NAME _____ BIRTHDATE _____ SEX _____

HOME ADDRESS: _____ PHONE: _____

PARENT'S NAMES: _____

Place of employment: Father _____ Phone: _____ Cell: _____

Mother: _____ Phone: _____ Cell: _____

IN CASE OF EMERGENCY, NOTIFY: _____ Phone: _____ Relationship: _____

OR: _____ Phone: _____ Relationship: _____

Doctor's Name: _____ Phone _____

Insurance Group: _____ Policy number: _____

My Child _____ is allergic to _____

My child receives therapy: OT ____ OP ____ Speech ____ Special Ed. ____ Counseling ____ None ____

Important: Has this child been exposed to any communicable disease during the three weeks prior to preschool attendance: YES NO

HEALTH HISTORY: (Circle if child has had afflictions or allergies, give appropriate dates)

- Rheumatic Fever _____
- Seizures _____
- Diabetes _____
- Asthma _____
- Chicken Pox _____
- Hay Fever _____
- Poisin Ivy, etc. _____
- Insect Stings _____
- Penicillin _____
- Other drugs _____
- Food _____

Other past illness _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, hearing aids, etc.) _____

Special Diet: _____ Special Medicine: _____

Suggestions from Parent: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Care/ Yiddishe Otzros program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship: _____ Signature _____ Date _____ Tel _____