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 _____