# Child's Health Record

| (Child's Name) | (D.O.B.) | (Sex) |
|---|---|---|
| | | |

Does your child have any of the following?

Known Allergies/ Sensitivities. Check One

| | | |
|---|---|---|
| **Medications:** | **Yes** ☐ | **No** ☐ |
| **Foods:** | **Yes** ☐ | **No** ☐ |
| **Other:** | **Yes** ☐ | **No** ☐ |

**(If you answered "Yes" to any of the above, please list them)**

Has your child ever had any of the illnesses listed below?

| | | | | | |
|---|---|---|---|---|---|
| **Chicken Pox** | **Yes** ☐ | **No** ☐ | **Measles** | **Yes** ☐ | **No** ☐ |
| **Wooping Cough** | **Yes** ☐ | **No** ☐ | **German Measles** | **Yes** ☐ | **No** ☐ |
| **Mumps** | **Yes** ☐ | **No** ☐ | **Rubella** | **Yes** ☐ | **No** ☐ |
| **Rheumatic Fever** | **Yes** ☐ | **No** ☐ | **Scarlet Fever** | **Yes** ☐ | **No** ☐ |

**(If you answered "Yes" to any of the above illnesses, please list the month / year that it occured)**

Does your child frequently suffer from any of the following?

| | | | | | |
|---|---|---|---|---|---|
| **Headaches** | **Yes** ☐ | **No** ☐ | **Ear Infections** | **Yes** ☐ | **No** ☐ |
| **Sore Throats** | **Yes** ☐ | **No** ☐ | **Upset Stomach** | **Yes** ☐ | **No** ☐ |

**(If you answered "Yes" to any of the above symptoms, please list the month / year that it occured)**

Does your child have any of the following?

| | | | | | |
|---|---|---|---|---|---|
| **Visual Impairment** | **Yes** ☐ | **No** ☐ | **Physical Impairment** | **Yes** ☐ | **No** ☐ |
| **Hearing Impairment** | **Yes** ☐ | **No** ☐ | **Emotional Problems** | **Yes** ☐ | **No** ☐ |

**(If you answered "Yes" to any of the above, please list them)**

Has your child had any surgeries? **Yes** ☐ **No** ☐

**(If you answered "Yes" to any of the above, please list them)**

Are all of your child's required immunization current? **Yes** ☐ **No** ☐

**(If you answered "No" above, please list which immunizations are needed below)**

My child's Medical provider is:

**Name:**

**Address:**

**Phones:**

**INS #** EMAIL

Date

*parent or guardian*

# Medication Administration Authorization and Log

(Child's Name) (D.O.B.) (Sex)

Name of Medication :

For Treatment of:

Method of Administration: ☐ Orally ☐ Topically ☐ Other (Specify)

Frequency / Times

Amount/Dosage:

Date Beginning:

Date Ending:

| Date | Time | Medication Name | Amount | Administered By |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I (Parent's/Guardian Name) authorize **Little Violet Daycare** (Provider Name)

to administer the above named medication*.

***(*Please note that all medication must be in its original container)***

Sign

*parent or guardian*

Date

## Non - Prescription
## Medication Permission

(Child's Name) (D.O.B.) (Sex)

I ____________ authorize **Little Violet Daycare**
(Parent's/Guardian Name) (Provider Name)

administer the following products on an as needed or as directed basis, in accordance with the manufacturer's directions.

| Product | Yes | No |
|---|---|---|
| **Acetaminophen** | **Yes** ☐ | **No** ☐ |
| **Anti-Bacterial Ointments** | **Yes** ☐ | **No** ☐ |
| **Antihistamine** | **Yes** ☐ | **No** ☐ |
| **Anti-Itch Cream** | **Yes** ☐ | **No** ☐ |
| **Baby Lotion** | **Yes** ☐ | **No** ☐ |
| **Baby Wipes** | **Yes** ☐ | **No** ☐ |
| **Band-aids** | **Yes** ☐ | **No** ☐ |

| Product | Yes | No |
|---|---|---|
| **Decongestant** | **Yes** ☐ | **No** ☐ |
| **Diapers Ointments** | **Yes** ☐ | **No** ☐ |
| **Ibuprofen** | **Yes** ☐ | **No** ☐ |
| **Insect Repellent** | **Yes** ☐ | **No** ☐ |
| **Neosporin** | **Yes** ☐ | **No** ☐ |
| **Sunscreen** | **Yes** ☐ | **No** ☐ |
| **Vaseline** | **Yes** ☐ | **No** ☐ |

**List any other non - prescription medication that you authorize application of:**

Sign ____________ Date ____________

*parent or guardian*