KidsCentre
Spring Street Post Alley
Infant to Pre-K Early Learning Center (206) 623-5437

Individual Health Care Plan

Child's Name: ____

Health History

Date of most recent physical? Well child visit:________________

Medical conditions or concerns of which we should be aware of?

____

____

Please check any of the fallowing that apply

_____Frequent colds	_____**Diabetes**
_____Frequent sore throats	_____**Asthma**
_____Frequent ear infections	_____Stomach upset
_____Skin rash	_____Urinary problems
_____**Heart trouble**	_____Frequent diarrhea
_____**Convulsions/Seizures**	_____Frequent constipation
_____**Fainting spells**	_____High fevers

Are you aware of any sight, hearing, or speech problems?

____

Allergies, food sensitivities, nutritional concerns ☐ **Yes** ☐ **No**

____

Procedure for emergencies from above list

____

Prescription medications (Given at home & if given at school)

____

Special Accommodations

(Sleeping, Eating, Toileting or Behavior interventions)

____

Special Materials/ Equipment (Glasses, Hearing aids, Nebulizer)

____

Training needed for staff : ☐ **Yes** ☐ **No**

If so, what is recommended? ____

Child's Doctor: ___________________________ **Phone :** ____________________

Address: ________________________ **Health insurance Carrier:** ________________

Policy number: ____________________ **Subscriber:** ___________________________

Childs Dentist: ____________________________**Phone:**____________________

Emergency Release and Authorization for treatment of a minor

In the event of a medical emergency and/or parents or authorized person noted above cannot be located, I nearby give consent and authorize the KidsCenter staff to administer first aid, arrange for emergency medical help an/or transportation to a medical facility via emergency or private ambulance. I authorize any medical examination, treatment and/or procedure determined to be necessary for my child. I expect that a conscientious effort will be made to locate me or my designated(s). I accept responsibility for any medical related expenses incurred.

Signature____ **Date**____________________

Signature____ **Date**____________________