MEDICAL HISTORY

(The top portion MUST be completed by your student's doctor.)

A health examination is required for each child admitted to **SONSHINE GARDENS DAYCARE & PRESCHOOL** program.

I have examined _____ (Child's Name) and find that he/she is free of infectious diseases.

Disabling conditions, physical or mental, affecting the child's participation in group activities:

_____

_____ _____

Date Signature of physician/nurse

_____

Physician's address Physician's telephone

(The bottom portion MUST be completed by student's parent or guardian.)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

In order to meet all legal requirements, I hereby authorize any representative of **SONSHINE GARDENS DAYCARE & PRESCHOOL** to give consent for any and all necessary emergency medical care for my child(ren) _____ while said child(ren) is (are) in the custody of this facility. I agree to assume responsibility of all medical costs incurred.

_____ _____

Date Signature of Parent or guardian

_____

Physician's Name, address and phone

EMERGENCY CONTACT:

_____

Name Relationship to child(ren) Phone

This form is designed to meet legal requirements established in HB1452, Acts of the 61st Legislature, Regular Sessions, which provides that any person who has custody of a minor may give consent to medical care if the person has an affidavit signed by one or both parents authorizing the person to give consent.

PERMISSION TO RLEASE INFORMATION

I understand that the time my child, _____ is in the facility, that the director may be asked for information regarding my child.

I hereby give permission to release information to official persons only, who identify themselves, such as school, health care personal, welfare or other government officials.

_____

Signature of Parent or Guardian Date

I do not give permission about my child as set forth in the aforementioned statement. I realize that the Bureau of Services for Child Care has access to my child's record as the licensing agent.

_____

Signature of Parent or Guardian Date