HEALTH & SAFETY INFORMATION

(2 page supplement to state form LIC702 "Child's Preadmission Health History")

FULL NAME OF CHILD: ______________________________ BIRTHDATE: ____________

OTHER NAMES CHILD GOES BY, IF ANY: __________________ GENDER: Girl ☐ Boy ☐

DIETARY INFORMATION

Are there any foods your child cannot eat here? No ☐ Yes ☐ If yes, please list:
FOODS: REASON (please specify date & type of past health reaction or if it's a personal choice):

Is your child a picky eater? Is there anything we should know about your child's eating habits?

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HEALTH INFORMATION

Does child have any current health problems? No ☐ Yes ☐ If yes, please describe:

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Children cannot carry any medicines (even homeopathic or herbal). A state form is required for us to administer any medicines, including sunscreen. Will we need to administer any medicines to your child? No ☐ Yes ☐
If yes, please describe:

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Is there any present or past history of, or suspicion of: (if yes, note year and description. Use back of paper if needed.)

Allergies other than foods (note foods above)? ______________________________________

Special needs (activity restrictions, learning disabilities, etc.)? ____________________________

Need for glasses? ____

Defects? ____

Surgeries? ____

Problems with: Nervous system (epilepsy, seizures, dizziness, fainting), back, limbs, joints, skin, glands, ears, eyes, nose, sinus, chest, lungs (inc. asthma), heart (murmur, rheumatic fever, other), stomach, bowels, appendix, hernia, kidneys, urine (including infection), psychological condition (anxiety, phobias, ADD, depression, etc.), or any other problem we should know about?

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PERSONAL INFO

Is there anything else you would like us to know about your child? (home life, custody arrangement, developmental, physical, mental, emotional, special concerns, calming techniques, guidance techniques, anything)

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HEALTH INSURANCE INFO

Insurance Company ____________________________ Phone # ______________________________

Policy # ____________________ Name of Insured & Date of Birth ______________________________

Preferred Physician __________________________ Phone # _________________________________

Address ____

Preferred Dentist ____________________________ Phone # _________________________________

Address ____

SAFETY INFORMATION

Is there anyone specific whom may not have contact with child (ex-spouse, etc.)? No ☐ Yes ☐

If yes, please state name of person and relationship to child:

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Is there a legal document preventing contact (divorce decree, restraining order, etc.)? No ☐ Yes ☐

If yes, state document type: ____