**La Casita Health Form**

**Family Information:**

Child’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_

Home address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician or medical facility to call in case of emergency:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance information:**

Name of insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID no:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group no:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Permission(s)**

Please check all that apply:

* If you would like us to apply sunscreen to your child in their afternoons at La Casita, please check the box and put a bottle of sunscreen (no spray-ons, please) in your child’s cubby with their name on it.
* If you would like us to safely apply Neosporin (or other antiseptic), when needed, to your child’s wounds.
* If you would like us to safely use, when needed, tweezers to remove splinters if your child gets one.
* For Afternoon Parents, if you would like us to use Fluoride toothpaste if your child has run out of their own toothpaste.

Parent signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Good Health** **(to be signed by child’s physician)**

I have examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and found this child to be in good health

and able to attend preschool and have conducted a vision and hearing screening.

Name of physician (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_