MEDICAL HISTORY

Date Completed:_____

Trinity College Community Child Center maintains a contract for the services of a visiting nurse consultant. The nurse consultant is on call to assist us with any and all health related questions. This medical form will accompany your child in case of emergency. Please be as detailed as possible in completing it. PLEASE PRINT.

CHILD'S NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

_____

PARENT'S/GUARDIAN'S NAME: _____

PARENT'S/GUARDIAN'S EMPLOYER: _____ WORK PHONE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS:_____

PARENTS/GUARDIAN'S NAME: _____

PARENT'S/GUARDIAN'S EMPLOYER: _____ WORK PHONE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS:_____

CHILD'S DOCTOR: _____ CITY/TOWN: _____

DOCTOR'S PHONE: _____ HOSPITAL AFFILIATION: _____

CHILD'S DENTIST: _____ DENTIST'S PHONE: _____

CHILD'S HEALTH INSURER AND POLICY NUMBER: _____

PLEASE ATTACH COPY OF HEALTH INSURANCE CARD

IN THE EVENT OF AN EMERGENCY, IF A PARENT OR GUARDIAN IS UNREACHABLE, I AUTHORIZE THE FOLLOWING INDIVIDUALS TO BE CONTACTED TO ACCOMPANY MY CHILD AND/OR PICK UP MY CHILD.

EMERGENCY CONTACT PERSONS (SAME AS ENROLLMENT FORM)

*PRINT FULL NAME	PHONE NUMBER	RELATIONSHIP TO CHILD
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

*THESE AUTHORIZED PICK-UP INDIVIDUALS MUST HAVE A MEANS OF POSITIVE IDENTIFICATION SUCH AS A DRIVER'S LICENSE OR PICTURE ID.

DOES THIS CHILD HAVE ANY OF THE FOLLOWING?

ALLERGIES TO FOOD OR MEDICINE (please list):_____

_____

ASTHMA: _____

_____

PAST MEDICAL HISTORY THAT HOSPITAL PERSONNEL SHOULD KNOW?

_____

_____

OTHER HEALTH RELATED CONDITIONS: _____

_____

PLEASE LIST ALL MEDICATIONS TAKEN ON A REGULAR BASIS: _____

_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should an emergency situation arise, I authorize the staff of the Trinity College Community Child Center to administer First Aid.

I authorize an emergency vehicle to transport my child to the nearest available medical facility appropriate to the emergency situation for treatment. I understand a staff member will accompany and remain with my child until a family member arrives.

I authorize emergency medical personnel to treat my child as needed.

I understand that the cost of emergency medical treatment, cost of the emergency vehicle and/or other medical costs incurred are my responsibility.

_____ _____

Print Child's Name Date

_____ _____

Signature of Parent/Guardian Signature of Parent/Guardian

_____ _____

Parent/Guardian's Name Parent/Guardian's Name