

# STATEMENT OF HEALTH STATUS (one child per form)

## Mountain Top Children's Museum

The child care program must obtain for every child who enrolls in child care programs a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled child care program. Updated yearly.

This statement is best filled out by a licensed physician or other health professional who has seen the child in the last twelve months; however a parent / guardian may fill out to the best of their ability.

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Surgery/Accidents/Illnesses/Chronic Health Problems:

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

Describe any condition(s) requiring the facility's special attention, use back of page if needed:

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

Special Diet Required: \_\_\_\_\_

Known **Intolerances**: \_\_\_\_\_

Known Drug Reactions: \_\_\_\_\_

Allergies (**please ask for additional paperwork, Required**):

\_\_\_\_\_

Medication(s) being taken: \_\_\_\_\_

Date most recent examination (**Required**) : \_\_\_\_\_

**Required** (we have local #'s and address on file if needed):

Physician Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of licensed physician or other health care professional (optional)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date