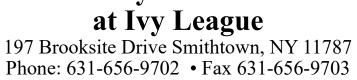
## **The Day Care Center**





## Health Survey (TO BE COMPLETED BY PARENT/GUARDIAN UNLESS OTHERWISE NOTED)

		`		<u> </u>	•						
PERSONAL INFO	RMATION										
CHILD'S NAME											
PARENT 1		CEL	L OR BEEPE	R	BUSINE	NESS PHONE					
PARENT 2		CEL	L OR BEEPE	R	BUSINE	SS PHONE					
HOME PHONE											
TIONE THORE											
CHILD'S MEDICA	L HISTORY										
DATE OF BIRTH	HEIGHT	WEIGHT		HAIR COLOR	EYE COLOR	DISTINGUISHING MARKS					
Special medical conditions											
2. Chronic illnesses											
3. History of serious injuries or hospitalizations of which we should be aware											
4. Special dietary needs											
5. Physical restrictions _						· · · · · · · · · · · · · · · · · · ·					
Hearing concerns	3										
-											
	• •										
6. Is your child able to ful	ly participate in all o	f the activities offe	ered by The I	Day Care Center at Ivy Lea	ague? □Yes □ No						
If no, please expl	ain			<del></del>							
7. Does your child function at the level of other children in his or her age group?											
If no, please explain.											
8. Is your child able to wa	ilk? □Ye	es 🗆 No									
If no, please expl	ain										
9. Is your child toilet train	ned? □Ye	s 🗆 No									
10. Can your child commu	nicate his or her need	ds? □Yes	□ No								
Please note if your child has	had any of the follow	ving (please check	( all that ap	ply):							
☐ Frequent colds/upper respiratory ☐ Heart Disease				☐ Asthma/i	breathing problems	□ Vision/hearing problems					
infections □ Lung disease/sho			rtness of breath 🗆 Abdominal (stomach) pain			□ Diabetes					
☐ Frequent sore throats ☐ Seizures/convulsions				☐ Urinary tr	ract infections/problems	□ Other					
☐ Frequent ear infections ☐ Frequent noseblee			eds	☐ Persisten	t diamhea						
☐ Frequent skin rashes		Fainting spells		□ Persisten	t constipation						
ALLERGY/DIET I	NFORMATIO	ON									
DOES YOUR CHILD HAVE ANY ALLERGIES?											
MEDICATION ALLERGIES	AYFEVER/SEASONAL										
ANIMALS			DUST		רס	THER					
Please note, if any allergy is severe or life threatening, The Day Care Center at lvy League will need a completed emergency action plan from you and your physician.											
DOES YOUR CHILD REQUIRE A SPECIAL DIET?   Yes   No If yes, please specify below.											

CHILD'S MEDICAL PROVIDER INFORMATION											
PRIMARY CARE PHYSICIAN		PRACTICE/CLINIC NAME									
PCP ADDRESS		PCP PHONE									
PREFERRED HOSPITAL/CLINIC FOR ACUTE CARE AND ER CARE *(SEE BELOW FOR EMERGENCY PROTOCOL)*											
FIGURE LINES HALF CLINIC FOR ACCIE CARE AND EN CARE "(SEE DELOW FOR EMERGENCI FROTOCOL)"											
MEDICAL POLICIES											
<ol> <li>Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information must be updated in accordance with state child care licensing regulations and kept current. I understand that children without appropriate current medical records may not attend the center.</li> <li>I agree to promptly provide information to the center regarding any conditions, illnesses, allergies, or other special needs that may require specific care or attention and agree to provide additional documentation as needed.</li> <li>If the center staff notifies me that my child is ill, I must pick up my child as soon as possible after being contacted.</li> <li>If my child contracts a reportable contagious disease, my child may return only with a physician/health care professional's note indicating that my child is no longer contagious. If my child becomes ill with fever, I understand that my child may return to daycare after no fever presents itself for a minimum of 24 hours.</li> <li>In case of a medical or other emergency while my child is under the center's supervision, I understand that The Day Care Center at ly League will attempt to contact me immediately; however, in the event that I cannot be reached, or when a delay would further jeopardize my child's health, I hereby authorize The Day Care Center at ly League to: Consult my child's physician if I cannot be reached; Administer first aid/CPR if necessary; Transport my child via ambulance or other emergency medical served to a local hospital if deemed necessary by a health professional; Obtain any emergency medical treatment deemed necessary by medical authorities.</li> </ol>											
<ol> <li>I must complete any state-specific medical authorization forms required by New York State child care licensing regulations.</li> <li>I authorize The Day Care Center at Ivy League to administer to my child topical non-prescriptions medications as needed, according to the dosage instructions on the medication container. For any other non-prescription medication, I will provide written authorization to administer the medication in addition to written instructions from my child's health care professional or me, as required. For any prescription medication, I will complete necessary authorization forms with my signature and understand the prescription label dosage must be followed. I will provide the medication in its original container with the pharmacist's label.</li> </ol>											
I certify that I have read, underst	and and accept all of terms an	d conditions			Ocata Disasta dall'ala						
Parent/Guardian Signature:			Date:		Center Director Initials:						
IMMUNIZATION HISTORY/ Parent and Physician - Please Note: The	<b>DTP</b> - 2, 4, 6, & 12 MONTHS	EMENI	<b>OPV</b> - 2, 4, 6 MONTHS, 4-6		OTHER IMMUNIZATIONS -						
Bureau of Child Development and Parent Education indicates that Section 2164 of the Public Health Law, amended, mandates pre-admission immunization against polio,	MMR- 12-15 MONTHS, 4-6 N	/EARS	<b>HEB</b> - BIRTH, 2, 6 MONTHS								
measles, rubella and diphtheria. The only exceptions are those children with valid medical exemptions. Please indicate ALL doses and dates of immunizations.	<b>HIB</b> - 1-2, 4 MONTHS, 1 YEAR	ł	VARICELLA - 1 DOSE		LEAD SCREEN - DATE/RESULTS						
1. Does the child have any health/medic	al condition(s) that could resu	It in an emerg	ency at the child care locat	ion?							
<ol> <li>Date of last physical examination?</li> <li>Is the child free of any infectious or co</li> </ol>	mmunicable diseases?	□Yes	□ No								
If no, are there any infectious or	communicable diseases that w			care program?							
Are this child's immunizations comple     If no, please explain		□Yes	□ No								
6. Is the child currently under medical treatment?											
7. Please list any medications this child takes											
If yes, please list specific medications, dosage and frequency instructions and attach a prescription for the medication to be administered.											
9. As a physician, please provide any additional information that you feel is important for The Day Care Center at Ivy League to know about this child.											
PHYSICIAN NAME	i i	PHONE NUMBER		NAME OF PRACTICE OR CLINIC							
ADDRESS		FAX NUMBER		LIC#							
SIGNATURE				DATE							