Health Requirements

NAME:_____ DOB:_____

Please include a complete record of the child's immunizations.

My child *had* the chickenpox disease on _____ .
Date of disease

_____ _____
Parent's signature Date Signed

Emergency Medical Authorization : PLEASE ***circle*** your choice of emergency medical facility below:

Arlington Memorial	Medical Center of Arlington	Cook Children's FW	Methodist Mansfield Medical Center

Physician_____ Phone # _____
Address_____

I give consent to and authorize CLC and its representatives to secure ***any and all*** necessary emergency medical treatment for my child, including transportation to the above circled facility.

X_____ _____
Parent or Guardian Signature **Date**

ADMISSION REQUIREMENT: One of the following must be presented when your child is admitted to CLC or within one week of admission. **Please check only one option:**

☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is able to take part in the day care program.

X_____ _____
Signature - Medical Professional Date

☐ A signed and dated copy of a health care professional's statement is attached.

☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

☐ PARENT'S STATEMENT: My child has been examined within the past year by a health care professional and is able to participate in the day care program. **Within 12 months of admission**, I will obtain a health care professional's signed statement and will submit it to CLC.

***IN ADDITION, PLEASE PROVIDE THE FOLLOWING INFORMATION AND SIGN BELOW:

Name, phone and address of health care professional:

_____

_____

X_____ _____
Signature - Parent or Legal Guardian Date