

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

EMERGENCY CONTACT INFORMATION AND PARENTAL CONSENT FORM DAY CARE

KEEP THIS CONSENT FORM HANDY SO THAT IT CAN BE TAKEN WITH THE CHILD IN CASE EMERGENCY MEDICAL CARE IS NEEDED

Child's Name:

Birth Date:

Address:

Mother's Name or Legal Guardian's Name:

Telephone No. (Home):

Address:

Business Address:

Telephone No. (Business):

Father's Name or Legal Guardian's Name:

Telephone No. (Home):

Address:

Business Address:

Telephone No. (Business):

Name and Address of person to be Contacted in Emergency (if parents are **not** available):

Telephone No.:

Name and Address of Child's Physician or source of Medical Care:

Telephone No.:

Special Disability (if any):

Any Special Medical or Dietary Information Necessary for Management in an Emergency Situation (allergies, medications, special conditions):

Any Additional Information on Special Needs of the Child:

Health Insurance Coverage for Child under Family Insurance Policy or Medical Assistance Benefits (if applicable):

Person(s) Designated by Parents to Whom the Child May be Released:

WRITTEN CONSENT IS GIVEN FOR:
(Please check those items for which you give your consent)

- EMERGENCY MEDICAL CARE
- ADMINISTRATION OF PRESCRIPTION MEDICATIONS **(Physician's Current Written Instructions Must Be Provided)**

ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS; PLEASE LIST ALL THAT MAY BE ADMINISTERED, AND DOSAGE:

ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS; LIST ALL THAT CAN BE ADMINISTERED, AND DOSAGE:

- TRIPS: TRANSPORTATION BY THE FACILITY FOR TRIPS
- DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (E.G MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

- YES NO If Yes, Specify:

- SWIMMING HOMEWORK SUPERVISION

HEALTH HISTORY

	<u>YES</u>	<u>NO</u>
Allergies or reaction: (food or other)	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever, asthma, or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Eczema or frequent skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds, sore throats, earaches, tonsillitis, pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Congenital defects such as cleft lip, cleft palate, etc.	<input type="checkbox"/>	<input type="checkbox"/>

	<u>YES</u>	<u>NO</u>
Measles (red, hard) Diagnosed by MD	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (German Measles) Diagnosed by MD	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with passing urine Or bowel movement	<input type="checkbox"/>	<input type="checkbox"/>
Other Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
Please Explain:		

Is the child right- or left-handed Right Left

Has discussion been held with the parent about the child's:

- a. schedule (napping)
- b. favorite activities
- c. toilet training
- d. forms of discipline?

SIGNATURE OF PARENT OR GAURDIAN:

DATE: