Central Early Childhood Center
Central United Methodist Church
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CHILDREN'S HEALTH FORM

Name _____ Birth Date _____ Age _____
(Last) (First) (Middle Initial)

Address _____ City _____ State _____ Zip _____ Phone _____

I give permission for my child's teachers (classroom, support, and/or extended day) as well as the CECC Directors to have access to my child's health records.

Parent/guardian signature: _____ **Date:**_____

Printed name: _____

Please attach immunization records to this form

Any past experience that has influenced his/her physical and/or mental health, such as an accident, exposure to toxins, etc.?

_____

_____

_____

Premature birth? ____No ____Yes If yes, child was born at _____ weeks.

Any physical concern, weakness or disability that Central ECC should take into consideration: (Hearing, sight, heart, allergies,

dietary intolerances, asthma, convulsions, diabetes, emotional problems, etc.) _____

_____

Prescription medications taken on a daily basis by child: _____

Any physical limitations or recommendations? _____

How does your child react to elevated temperatures? _____

******A PHYSICIAN OR HEALTH DEPARTMENT OFFICIAL MUST COMPLETE & SIGN THE FOLLOWING SECTION:******

Child's Name _____

- has been examined and is found to be free from contagion and able to participate in all Central Early Childhood Center activities.
- is current on all immunizations as required by the state of Missouri.
- **I have included/attached a copy of the child's official immunization record.**

Physician/Health Dept. official signature_____ Phone_____

Address _____ Date _____

City/State/Zip _____