HEALTH STATEMENT

CHILD'S NAME: _____BIRTH DATE: _____

PARENT'S NAME: _____

PARENT'S ADDRESS: _____

STATUS OF THE ABOVE CHILD'S HEALTH_____

ANY KNOWN CONDITIONS UNDER TREATMENT _____

CHILD IS CAPABLE OF ADJUSTING TO PROGRAMS OF THE CHILD CARE FACILITY YES/NO –

REASON _____

SIGNED _____DATE_____
(M.D. OR R.N.)

PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATION/TOPICAL CREAMS

ALL OINTMENTS AND MEDICATIONS MUST BE PROVIDED IN THEIR ORIGINAL CONTAINER, WITH A VALID EXPIRATION DATE, WHERE APPLICAPABLE, LABELED CLEARLY WITH THE CHILD'S NAME, AND GIVEN DIRECTLY TO A TEACHER. TEACHERS MAY ONLY DISPENSE OINTMENTS AND MEDICATIONS PER LABELED INSTRUCTIONS. THIS SECTION IS TO BE FILLED OUT BY A PHYSICIAN.

Medication	Dosage	Reason for Administration	Physician Signature
Ibuprofen			
Acetaminophen			
Diaper Cream			
Topical Skin Cream			
Teething Tablets			
Gas Drops			
Sunscreen			

Parent Signature_____