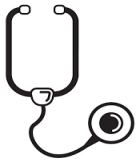
Trinity Lutheran Child Learning Center

HEALTH INFORMATION 2022-2023



Child's Name _____ Male/Female _____ Birth date_____

Insurance: None ❒ Plan Name & ID # _____

Doctor or Clinic _____ Phone # _____ Well Exam in last 1 yr ❒ 2 yr ❒

Dentist _____ Phone # _____ Dental Exam in last 1 yr ❒ 2 yr ❒

AUTHORIZATION FOR MEDICAL CARE

I understand I will be notified at once in case of an accident or illness to my child, and I will make arrangements for medical care of my child with the physicians or hospital of my choice. If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I hereby authorize TLCLC to contact:

Doctor_____Phone #_____

Hospital_____Phone #_____

My child has no current health concerns. ❒ OR My child has the following special health concerns:

EYES: glasses ❒ contacts ❒ (for reading or distance?) _____ lazy eye ❒ difficulty seeing ❒ surgery ❒ other ❒
Explain: _____

EARS: frequent infections ❒ tubes ❒ date inserted _____ hearing difficulty ❒ hearing aid Right ❒ Left ❒
Explain: _____

MEDICATIONS: at home ❒ at school ❒ Explain: _____

SPECIAL EDUCATION OR SERVICES: Speech/Language❒ OT/PT❒ Other_____
Requires special health care (explain) _____

OTHER HEALTH / MOBILITY CONCERNS: Explain: _____
_____

ALL HEALTH CONCERNS REQUIRE A PHYSICIAN'S STATEMENT AND A PLAN DETAILING DAILY CARE

ALLERGIES: Food Allergies:_____
Food Intolerances:_____
Seasonal:_____
Other (drugs, insects, etc):_____
Has the allergy required emergency action in the past? Yes ❒ No ❒

ALLERGY / INTOLERANCES REQUIRES A PHYSICIAN'S STATEMENT, DAILY CARE AND EMERGENCY ACTION PLAN

ASTHMA: Yes ❒ No ❒ Triggered by: _____ Treatment: _____
Diagnosed by: _____ Date_____

ASTHMA REQUIRES A PHYSICIAN'S STATEMENT, DAILY CARE AND EMERGENCY ACTION PLAN

IMMUNIZATIONS:

Missouri State Law, Admission Policies and Procedures: Facility shall receive information indicating that the child has completed age appropriate immunizations, is in the process of completing immunizations, or is exempt from immunizations as defined by 19 CSR 30-62.192 Health Care.

I have provided a copy of a full Immunization Record or any new immunizations. ❒

My signature below verifies the above information to be accurate.

Signature of Parent/Guardian _____ Date _____