CHILD'S HEALTH HISTORY REPORT

Child's Name ___________________________ Sex _______ Birth Date ________________

Father's Name _________________________ Mother's Name ________________________

Does your child have any allergies? No_____ Yes _____

If "Yes" please list any and all allergies: ____

____

Does your child have any medical conditions that we should be aware of?

No _____ Yes _____

If "Yes" please list any and all conditions: ____

____

_________________________________ ________________________

Parent's Signature Date

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICE
COMMUNITY CARE LICENSING

CONSENT FOR MEDICAL TREATMENT

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO ROSEVILLE COMMUNITY PRESCHOOL TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (O.D.) OR DENTIST (D.D.S.) FOR

_____________________________________.
CHILD'S NAME

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES: ____

_____________________________________ _____________________________________
PARENT SIGNATURE DATE

_____________________________________ _____________________________________
HOME ADDRESS HOME PHONE

_____________________________________ _____________________________________
CITY ZIP WORK/ALT. PHONE