**Child’s Statement of Health Status for Enrollment**

Children in ECE must submit a signed and dated statement of the child’s current health status upon admission which indicates the child’s ability and/or limitations to participate in a regularly scheduled program in a group of young children. Parents may use this form, or a statement of health status with the same information as provided by their child’s health provider. ***This report is to be completed by a health care provider who has seen the child in the last twelve months.***

**No later than 30 days after admission, this report or a written verification of a scheduled appointment with a health care provider must be given to the school. The ECE program may refuse to admit a child if a statement from an approved health care professional is not submitted.**

*Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City & Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

* Date of child’s most recent examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date next visit is required:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Known allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Medications being taken and possible side effects:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Prescribed routine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Past Illnesses ‐ Check those the child has had and give approximate dates:

|  |  |
| --- | --- |
| Chicken Pox\_\_\_\_\_\_\_\_\_\_\_\_  | Rubeola\_\_\_\_\_\_\_\_\_\_\_\_ Rubella\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Rheumatic Fever\_\_\_\_\_\_\_\_  | Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_ Hay Fever\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Mumps\_\_\_\_\_\_\_\_\_\_\_\_\_ Epilepsy\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Whooping Cough\_\_\_\_\_\_\_\_  | Poliomyelitis\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

* If tuberculin test given: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If chest X ray taken: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Date of screening for: Vision\_\_\_\_\_\_\_\_\_\_\_\_ Hearing\_\_\_\_\_\_\_\_\_\_\_\_ Dental\_\_\_\_\_\_\_\_\_\_\_\_ Developmental\_\_\_\_\_\_\_\_\_\_\_\_

 was child referred for further evaluation (circle one)? Yes / No

* Surgery/Accidents/Illnesses/Chronic or Handicapping Problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Describe any physical condition requiring special attention by staff:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* This child is \_\_\_\_\_\_ is not \_\_\_\_\_\_ physically and/or emotionally able to participate in the DPS ECE program. Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Health Provider Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City & Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Signature of licensed physician or licensed nurse practitioner***   |  |  |  | ***Date***  |