************** **CONSENT FOR MEDICAL TREATMENT** ****************

Doctor:_____________________ #:_________________ Insurance:_________________

Address:_______________________________________ Plan #:____________________

Dentist:_____________________ #:_________________ Insurance:_________________

Address:_______________________________________ Plan #:____________________

As the parent, or legal guardian, I give consent to Shining Light Preschool to provide all emergency medical or dental care prescribed by a licensed Physician or Dentist for my child: _________________________. This care may be given under whatever conditions are necessary to preserve life, limb, or well being of my child.

Medication allergies known to date: ____

Allergies known to date: ____

Date:______________ Signature:____

*************** **PRE-ADMISSION HEALTH HISTORY** *****************

PAST ILLNESSES: Check & date if applicable. Leave blank if N/A.

___ Chicken Pox:_______________________ ____ Asthma:________________

___ Hay Fever:_________________________ ____ Mumps:________________

___ Rubeola (10 Day Measles):___________ ____ Epilepsy:_______________

___ Rebella (3 Day Measles):_____________ ____ Diabetes:_______________

Other illnesses:____

Date of last regular check-up with physician:___________________________________

List of serious injuries:____

***************** **PARENT'S EVALUATION of CHILD** *****************

Evaluation of Child's Health:____

____

Evaluation of Child's Personality:____

____

Special Problems/Fears of Child:____

____

Previous Care for child:____

******************* **OUT-OF-STATE CONTACT** *********************

If intrastate phone lines are down during a disaster, SLP can use this out-of-state # as a contact.

Name:_______________________ #:_________________ Relationship:_____________