Child's Statement of Health Status

All child care facilities must retain a signed and dated statement of each child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled child care program. Preschoolers must have this form filled out and signed by a licensed health care professional. Parents of school aged children may fill out and sign this form, it does not need a health care professional's signature.

Child's Name_____**Sex**_____**Date of Birth**_____

Address_____

Past Illnesses: Give approximate dates of when child had illness

_____**Chicken Pox**	_____**Rubeola**	_____**Rubella**	_____**Rheumatic Fever**
_____**Asthma**	_____**Hay Fever**	_____**Diabetes**	_____**Mumps**
_____**Epilepsy**	_____**Whooping Cough**	_____**Poliomyelitis**	_____**Other**

Comments: _____

Date of tuberculin test (if given):_____ **Date of chest x-ray (if taken):**_____

Vision Normal or Requires Corrective Lenses_____ **Hearing Normal or Requires Aid**_____

Surgery/Accidents: _____

Illnesses/Chronic Health Problems:_____

Allergies:_____

Current Allergy Treatment(s):_____

Describe any physical condition requiring special attention:_____

_____

Current Prescribed Medication(s):_____

*IF PRESCRIPTION MEDICATION IS TO BE GIVEN AT CAMP/SCHOOL YOU WILL NEED TO FILL OUT THE **"INDIVIDUAL CHILD'S RECORD OF MEDICATION ADMINISTRATION" FORM.** (available at the front office).

This record must be signed by the parent authorizing staff to administer medication. All prescription medication must be given to your child's head camp counselor/teacher in it's **original prescription bottle** and must be labeled with written permission from your medical provider and the parent. This label must contain the child's name, physician's name, pharmacist, name of medication, dosage, frequency, starting date and expiration date, if applicable.

Date of last examination of child:_____

NAME OF HEALTH CARE PROFESSIONAL:_____

ADDRESS: (include street/city/zip):_____

PHONE NUMBER:_____

NAME OF CHILD'S DENTIST:_____

ADDRESS: (include street/city/zip):_____

PHONE NUMBER:_____

Signature(s) below verify that this information is correct and current with pediatric guidelines:

PARENT Signature: X_____**Date:**_____

(**Required for preschool and school age children)**

PHYSICIAN'S Signature: X_____**Date:**_____

(**Required for preschool age children)**

***NOTE:** Proof of immunizations is also required and must be on the Colorado State Department of Health standardized form.