



Performing Arts and Languages Daycare

PALS Daycare-Performing Arts and Languages

7724 SE Aspen Summit Drive

Portland, OR 97266

Phone: 503-206-6166

Medical Information

Child's Name _____ Date of Birth _____ Sex _____

Doctor's Name _____ Address _____ Phone _____

Food Allergies _____ Known Medical Problems _____

MEDICATION

List all medications taken _____

If medication is needed during childcare hours, you will need to complete a medication authorization form that lists the type of medication, dosage, and frequency it should be administered. This is necessary for over the counter and prescription medication. If the medication is prescription it must have the child's name on the prescription container. Over the counter medication also needs to be labeled.

Has the child has/had any injuries resulting in fractures or loss of consciousness?

(Explain) _____

Last vision test _____ Last dental visit _____ Last hearing test _____

EMERGENCY CONTACT (if Parent/Guardian not available)

Name _____ Relationship to Child _____

Address _____ Phone _____

Cell Phone _____

Hospital Preference _____

Parent/Guardian Signature _____ Date _____



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Medical Report

PALS DAYCARE WOULD APPRECIATE THE RETURN OF THIS COMPLETED FORM TO THE CENTER DIRECTOR PRIOR TO CHILD'S ATTENDANCE AND UPDATED ANNUALLY.

Child's Name _____ Birth Date _____ Sex _____

IMMUNIZATION RECORD

Parents are required to provide log of child's immunization records. Parents will be asked to bring a record of any new immunizations received throughout the child's attendance at the center.

HEALTH EXAMINATION – Check correct option below and complete information that follows.

- 1) _____ A complete physical examination was given on (Please enter date) _____.
- 2) _____ A current examination was waived due to _____.

TESTS DATE RESULTS

Tuberculin skin or chest x-ray _____
Other (specify) _____

	1 MM/DD/YY	2 MM/DD/YY	3 MM/DD/YY	4 MM/DD/YY	5 MM/DD/YY
DIPHTHERIA, TETANUS, PETUSSIS					
HIB					
POLIOMYELITIS					
MEASLES					
RUBELLA					
MUMPS					
MEASLES, MUMPS, RUBELLA					
HEP. B					
VARICELLA					

Chicken Pox (Year) _____ Scarlet Fever (Year) _____
Frequent Ear Infections _____ T.B./T.B. Contact (Year) _____

CHILD'S CURRENT PHYSICAL LIMITATIONS, SPECIAL NEEDS OR DISABILITIES (For example: allergy, diabetes, heart disease, H.I.V., hepatitis, epilepsy or hospitalization in the past 12 months, and any medication prescribed for long-term, continuous use.) _____

Allergies (List) : _____ Routine Medications : _____
Dietary Restrictions: _____ Disabilities (Please be specific): _____

PHYSICIAN'S RECOMMENDATION

This child may be admitted to a group child care facility. Yes No Comments _____

Physician's Name _____ Physician's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____