

Health and Safety Form

Moyock Baptist Church Preschool

Child's Name _____ Birthdate _____

Parent or Guardian Name _____

Medical History (to be completed by parent or guardian)

1. Does your child have any allergies? yes no
If yes, please explain.

2. Is your child currently under a doctor's care? yes no
If yes, please explain.

3. Is your child on any continuous medication? yes no
If yes, please list the name of the medication(s) and the reason it is being given.

4. Has your child ever been hospitalized? yes no
If yes, please list dates and reasons for hospitalization.

5. Does your child have any history of:
 - diabetes yes no
 - convulsions yes no
 - heart problems yes no
 - significant disease or recurrent illness (please list) yes no

 - other conditions (please list) yes no

6. Does your child have any mental or physical disabilities? yes no
If yes, please explain.

Signature of Parent or Guardian _____

(Please attach a copy of your child's birth certificate and a copy of your family's health insurance card)

Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners, a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT programs.

Height _____ Weight _____
 Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____
 Throat _____ Neck _____ Heart _____ Chest _____ GU _____
 EXT _____ Neurological System _____ Skin _____

Results of Tuberculin Test if given: Normal _____ Abnormal _____ Date _____

Should activities be limited? yes no If yes, please explain.

Any other recommendations?

Signature and title of authorized examiner _____

Date of Examination _____ Phone Number _____

Office Address (may use stamp)

Immunization History: The church staff or health official must enter the date immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all childcare facilities to have this information on file.

Age	DTP or DTaP *	Polio *	MMR *	HBV *	Hib *	Var
Birth						
2 months						
4 months						
6 months						
12 -15 months						
12 - 18 months						
4 - 6 years						

• Required by law.

Emergency Contact

List one local person who will be available to assume responsibility for your child in an emergency if parents cannot be reached.

Name _____ Relationship to Child _____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

Work Phone _____ Home Phone _____ Cell Phone _____

Emergency Medical Care

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize Moyock Baptist Church Preschool staff to take my child to an Emergency Room or to the following physician or his/her associates for medical care. I also authorize emergency medical treatment provided by certified fire and rescue personnel.

Dr. _____ Hospital _____

Address _____ Phone _____

City _____ State _____ Zip _____

Special Instructions _____

I give consent for any and all treatment deemed necessary by the attending physician.

(Signature of Parent/Guardian)

State of _____ County of _____

This instrument was acknowledged before me on (date) _____ by _____

(Notary Seal)

(Signature of Notary Public)

Persons Authorized to Pick up Child

I authorize that my child, _____, be released by
Moyock Baptist Church Preschool to the following persons, in addition to parents and/or legal guardians listed
on the enrollment form.

Name _____ Relationship to Child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Name _____ Relationship to Child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Name _____ Relationship to Child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Unauthorized Access

Please list below any person that absolutely **DOES NOT** have authorization to pick up your child.

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Name _____ Relationship to child _____