2064 Oxford Street
Houston, Texas 77008
heightspreschool.com
713.880.5437 p
713.880.2064 f

CHILD HEALTH RECORD

Child's Name: ________________________________ DOB: ____________________________

Name of health insurance carrier ____

Policy Number ____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

in the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to: ____

____

Name of Licensed Physician ____
Address ____________________________________ Telephone ___________________________

Or to (name of hospital or clinic) ____
Address ____________________________________ Telephone ___________________________

I give my consent for necessary emergency treatment when my child is in the care of the physician and/or hospital/clinic.

Signature of parent or guardian ______________________________ Date ____________________

TO BE COMPLETED BY PHYSICIAN ____
physicians's signature

Does this child have any chronic illness requiring regular medication or special precautions in a child care setting (recurrent ear infections, seizure disorder, asthma, allergies)? ______________________________

____

Any factors that could influence this child's adapting to a child-care setting (physical handicap, sensory loss, developmental irregularities)?

Medical factors pertinent to diagnosis and treatment in case of emergency? ________________________

____

Recommend limitations or modifications of activities or diet? _

____

Relevant family, social or health characteristics? ____

____

Please return this form with a current copy of immunizations to:

Heights Preschool	Or
2064 Oxford St	Fax 713.880.2064
Houston, TX 77008	kelly@heightspreschool.com