Health and Safety Form

Moyock Baptist Church Preschool

Child's Name _____ Birth date _____

Parent or Guardian Name _____

Home Address _____

City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____

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**)

OVER

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_____

Name_____ Relationship to Child _____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone _____

Cell Phone_____

Name_____ Relationship to Child _____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone _____

Cell Phone_____

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_____