Health and Medical History

Date:________________

Student Information

Child's Last Name: ___________________________ First: ________________________ Middle: ___________

Grade: ______________ School: ____________________________________ Birthdate: _________________

Child's Primary Contact Information:

Home Address: ____

City: ___________________________________ State: ___________ Zip: __________________

Child's Cell Phone: _________________________ School Email: ____________________________________

Gender: ______________________

Ethnicity: ☐ Asian/Pacific Islander ☐ Black/African American ☐ White/Caucasian

☐ Latino/Hispanic ☐ Native American ☐Multi-ethnic, please specify: __________________

Family Information

Child lives with: ☐Mother ☐Father ☐Both: Together ☐Both: Separately ☐Other: ___________________

Primary Parent/Guardian Name: ________________________________ Relation: ______________________

Home Address: __________________________________ City: _________________ State: _______

Home Phone: ____________________ Cell: ___________________ Email: _____________________________

Employer: ____ Job Title: ____________________________

Work Phone: __________________________ Work Email: __________________________

Secondary Parent/Guardian Name: ________________________________ Relation: ____________________

Home Address: __________________________________ City: _________________ State: _______

Home Phone: ____________________ Cell: ___________________ Email: _____________________________

Employer: ____ Job Title: ____________________________

Work Phone: ___________________________ Work Email: __________________________

Other Children in Family: **Lives at Home**

Name: ___________________________ Gender: ___________ Date of Birth: _____________ ☐Yes ☐No

Name: ___________________________ Gender: ___________ Date of Birth: _____________ ☐Yes ☐No

Name: ___________________________ Gender: ___________ Date of Birth: _____________ ☐Yes ☐No

Name: ___________________________ Gender: ___________ Date of Birth: _____________ ☐Yes ☐No

Other people living at home and relation to child:

Name: ____________________________________ Relationship:_________________________

Name: ____________________________________ Relationship:_________________________

Name: ____________________________________ Relationship:_________________________

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Vision Diagnosis

Vision Diagnosis: ____

☐ Low Vision (some vision, but significantly impaired) ☐ Blind (no light perception)

Does your child have prescription glasses? ☐ Yes ☐ No If yes, does your child wear them? ☐ Yes ☐ No

Reading Medium: ☐ Not Yet Determined ☐ Non Reader ☐ Large Print ☐ Braille ☐ Audio

Hearing Impairment: ☐ Yes ☐ No Degree of Loss (if any):____

Mobility Devices: ☐ No Devices ☐ Cane ☐ Modified Cane/Walker ☐ Wheelchair

Assistive Technology: (please list all devices used) ____

Special Education Disability Areas (check all that apply)

☐ Autism ☐ Deaf-Blindness ☐ Developmental Delay ☐ Emotional Disturbance ☐ Functional Delay

☐ Intellectually Gifted ☐ Cognitive Delay ☐ Orthopedic/Physical Impairment

☐ Speech/Language Impairment ☐ Traumatic Brain Injury

☐ Specific Learning Disabilities (please specify): ____

☐ Other Health Impairment (please specify): ____

☐ Other (please specify): ____

____

____

☐ No Additional disabilities and on grade/age level ☐ No additional disabilities and NOT on grade level

Diet, Allergies, and Additional Assistance

Diet: ☐ Regular ☐ Feeding Tube ☐ other (please explain)____

Medical or Religious Dietary Restrictions: ☐ N/A (Can Eat Anything) ☐ Vegetarian ☐ Vegan

Cannot Have: ☐ Gluten ☐ Dairy ☐ Other:____

Lavatory: ☐ No assistance required ☐ Some assistance required ☐ Requires diaper with full assistance

Does your child require a full-time assistant? ☐ Yes ☐ No

Allergies (Medication, food, animals, other)	**Reaction and management of reaction**
______________________________	____
______________________________	____
______________________________	____
______________________________	____

Please note: CLC does not allow peanuts and/or peanut based products for snacks and meals. CLC does provide programs with animal interactions. Please make sure your responses are thorough and detailed.

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Insurance, Medical Treatment, and Consent for Emergency Care

Primary Insurance – Is the participant covered by family medical/hospital insurance? ☐Yes ☐ No
Carrier/Plan Name:_______________________________________ Group#: ___________________________
Carrier Address: ____
Name of Insured: ______________________________ Relationship to Participant:_______________________
Insurance ID Number: ___________________________ Social Security #_______________________________

Secondary Insurance – Is the participant covered by family medical/hospital insurance? ☐Yes ☐ No
Carrier/Plan Name:_______________________________________ Group#: ___________________________
Carrier Address: ____
Name of Insured: ______________________________ Relationship to Participant:_______________________
Insurance ID Number: ___________________________ Social Security #_______________________________

Medical Treatment while at CLC:

The following over-the-counter medications are used at CLC under the recommendation of CLC's overseeing physician and nurse.

☐ **I give permission for the following medications to be administered for common ailments:** Feel free to cross out any products that you do not want your child to have.

Tums	Lip Balm	Cough Drops	Bee sting swabs	Benadryl
Tylenol	Advil	Sunscreen	Aloe Vera gel	Antibiotic cream
Saline Eye Drops	Opcom-A Eye Drops (for allergy relief)			

Authorization to Provide Necessary Treatment or Emergency Care

I hereby give permission to medical personnel selected by CLC staff, to order x-rays, routine tests, or other treatment; to release any records necessary for insurance purposes; to release a diagnosis and prescription to CLC staff; and to provide or arrange any necessary related transportation for my child. If I cannot be contacted, I hereby give permission to the physician selected by CLC to secure and administer treatment, including hospitalization. This completed form may be photocopied for programs outside of CLC's center. Both sides of this form are correct and complete as far as I know, and the person herein described has permission to engage in all CLC activities except as noted on this form.

Parent/Guardian's Signature ____

Print Name: ____ Date: ______________________________