

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

| | | |
|--|------------------------|--------------------------------------|
| Name (Last, First, MI) | Birthdate (mm/dd/yyyy) | First Day of Attendance (mm/dd/yyyy) |
| Home Address (Street, City, State, Zip Code) | | |

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

| | | | |
|------|--------------------------|-----------------------|----------------------------|
| Name | Primary Telephone Number | Work Telephone Number | Secondary Telephone Number |
| Name | Primary Telephone Number | Work Telephone Number | Secondary Telephone Number |

PHYSICIAN / MEDICAL FACILITY INFORMATION

| | | |
|----------------|--------------------------|------------------|
| Physician Name | Medical Facility Address | Telephone Number |
|----------------|--------------------------|------------------|

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

| | | |
|--|------------|---------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child. | Brand Name | Ingredient Strength |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen. | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child. | Brand Name | Ingredient Strength |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent. | | |

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

- | | | |
|---|--|---|
| <input type="checkbox"/> No specific medical condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal or feeding concerns, including special diet and supplements |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / seizure disorder | <input type="checkbox"/> Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism |
| <input type="checkbox"/> Cerebral palsy / motor disorder | | |
| <input type="checkbox"/> Other condition(s) requiring special care – Specify. | | |

- Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
- Food allergies – Specify food(s).
- Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

a.

b.

c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____