NEBRASKA Division of Public Health - Licensure Unit - Children's Services Licensing Program
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Children's Record

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name:_____ Birthdate(s):_____

Enrollment Date:_____ Updates:_____ Date Care Ceased: _____

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: _____ Employer:_____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

MOTHER (or Guardian):

Name: _____ Employer:_____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to _____
Caregiver

to contact Doctor _____ _____
Name of Physician Phone

_____ and, if necessary, take my child(ren) to the
Address City

following doctor(s), clinics, or hospital _____

_____ _____
Signature of Parent/Guardian Date

MEDICATION COMPETENCY STATEMENT

I,_____have determined
Parent /Guardian Name

that_____is/are competent to give or apply medication to my child(ren).
Provider/Director/Staff Name(s)

_____ _____
Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

Current health status or any health problems caregiver should know: _____

Medication, if any: _____

List any allergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: _____

Special Concerns: (Glasses, Hearing Aid, Crutches)_____

Any activities child(ren) should NOT engage in: _____

Company providing health and/or accident insurance coverage: (Optional) _____

I certify that the above information is correct to the best of my knowledge.

_____ _____
Signature of Parent/Guardian Date