The Shooting Stars Program

MEDICAL INFORMATION

Admission Date: _____

Name of Child:_____ Birth date: _____

"I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for child care staff to obtain whatever treatment may be deemed necessary for
_____,

This authorization includes my consent for the above named child to receive treatment by a physician in any hospital emergency department.
I hear by give my authorization for emergency medical treatment as outlined above.

Known allergies:

Known medical problem:

The Department of Health and Human Services requires that all Nursery School licensed facilities maintain copies of immunization records of each child. Please attach a copy of your child's immunization records.
____ **yes,** immunization records are attached and signed by **child's pediatrician**.
____ **No**, immunization records are not included because I choose to decline immunizations due to sincere religious and/or philosophical beliefs. If you choose not to have your child immunized, please be aware that your child will have to remain at home in the event that there is a break out of a serious contagious disease. The Center for Disease Control will develop a plan on when your child can return to school

_____ _____
(Parents or Guardian Signature) (Date)

_____ _____
(Director Signature) (Date)

I understand that in the event that a staff member from The Shooting Stars Program is required to install and buckle my child into a car seat, that I give permission for only employees of the Shooting Stars Program to place my child _____(child's name) in a car seat in a car other than my own and buckle my child into that car seat. I also understand that The Shooting Stars Employee and/or Director is not liable for any injury that may occur while riding in that car.

_____ _____
(Parent Signature) (Date)