CHILDREN'S RECORD
Nebraska Department of Health and Human Services

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PARENTS: PLEASE FILL IN ALL BLANKS

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

Enrollment Date: _____ Last Enrollment Date: _____

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:_____

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:_____

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

Transportation Permission

I hereby give _____ permission to transport or
Name of Facility

arrange for transportation of my child _____
Name of Child(ren)

I understand staff will insure that my child(ren) is placed in the appropriate safety restraint as indicated by Nebraska law at all times the vehicle is in motion.

_____ _____
Signature of Parent/Guardian Date

printed on recycled paper
CRED-0363 Rev. 6/07 (52042)
(Do Not use previous version)

Medication Competency Statement

I, _____ have determined
Parent /Guardian Name

_____ competent to give or apply medication to my child(ren).
Provider/Director

_____ _____
Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

Any health problems which caregiver should know: _____

Medication, if any: _____

Allergies, if any: _____

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

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

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

Certificate of Immunizations

VACCINE	TYPE OF VACCINE	Dose	Normal Schedule	Date Given Mo. Day Yr.	DOCTOR OR CLINIC ADMINISTERING
Polio OPV or IPV		1	2 mo.		
		2	4 mo.		
		3	6-18 mo.		
		4	4-6 yrs.		
DTP/DT/DTaP Diphtheria Tetanus Pertussis		1	2 mo.		
		2	4 mo.		
		3	6 mo.		
		4	15-18 mo.		
		5	4-6 yrs.		
Tdap		1	11-18 yrs.		
Td/Tetanus and Diphtheria					
Hib Haemophilus influenzae b		1	2 mo.		
		2	4 mo.		
		3	6 mo.		
		4	12-15 mo.		
M-M-R		1	12-15 mo.		
		2			
Hepatitis A		1			
		2			
Hepatitis B		1			
		2			
		3			
Varicella Chickenpox		1	12-18 mo.		
		2			
date of disease					
Meningococcal Conjugate		1			
PCV Pneumococcal Conjugate		1	2 mo.		
		2	4 mo.		
		3	6 mo.		
		4	12-15 mo.		
Rotavirus		1	2 mo.		
		2	4 mo.		
		3	6 mo.		

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

_____ _____
Signature of Parent/Guardian or Physician Date