CHILDREN'S RECORD
Nebraska Health and Human Services System

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

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 Address City

and, if necessary, take my child(ren) to the following doctor(s), clinics, or hospital:_____

_____

_____ _____
Signature of Parent/Guardian Date

(See other side)

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

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

Month and Year of Each Dose

DTaP 1_____	IPV 1_____	HIB 1_____	MMR 1_____	HEP B 1_____	VZV 1_____
DTaP 2_____	IPV 2_____	HIB 2_____	MMR 2_____	HEP B 2_____	VZV 2_____
DTaP 3_____	IPV 3_____	HIB 3_____		HEP B 3_____	
DTaP 3_____	IPV 4_____	HIB 4_____			
DTaP 5_____					

DTaP – Includes DtaP and DTP (Diphtheria, Tetanus, Pertussis)
DT (Diphtheria, Tetanus–Pediatric)
Td (Tetanus, Diphtheria–Adult)

IPV – Includes OPV (Oral Polio Vaccine)
IPV (Injectable Polio Vaccine)

HIB – Haemophilus Influenzae Type B
MMR – Measles, Mumps, Rubella
Hep B – Hepatitis B
VZV – Varicella

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

_____ _____
Signature of Parent/Guardian or Physician Date