Parent Instructions:

Please bring this form to your child's health care provider. Have the health care provider fill out the bottom half of the form.

Please make sure the physician fills out the form COMPLETELY. Any missing information may exclude your child from care.

Based on the physician's diagnosis, I will determine if your child will be allowed to return to care. Please do NOT ask the physician to make that decision as I am responsible for the health and safety of the children in enrolled in my program.

Please keep in mind that your child may be excluded from care for more than the standard 24 hours if the illness or physical condition of the child requires more care, attention and/or supervision than I am able to provide during the course of our normal day or if the symptoms and/or behaviors of the child interfere with regular daily activities.

Examples of this are severe coughing, excessive nasal discharge, poor disposition, inability to eat, sleep or participate in normal daily activities.

NO child will be allowed to attend if they are confined to indoor activity only and/or exhibiting behaviors that pose a risk or threat to other children in care.

The health and physical condition of all children in my care is a priority and affects all of us. Please use your best judgment when evaluating your child's condition and whether or not your child attends care when not feeling 100%.

If you have any questions, please feel free to contact me any time.

Failure to report a contagious illness and/or masking a fever or illness via OTC medications is grounds for IMMEDIATE termination of services.

Health Care Provider Evaluation Form

CHILD'S NAME:_____ DATE _____

The following signs and/or symptoms have been observed and noted:

Vomiting ___ Diarrhea ___ Rash ___ Respiratory Signs ___

Eye drainage___ Fever___ Coughing Wheezing ___ Dark Urine ___

Light Stool ___ Mouth Sores ___ Skin Lesions ___ Jaundice

Other concerns in our daily health observations:

_____

_____

_____

For your information, cases of: _____ have been reported in others attending our program.

HEALTHCARE PROVIDER:
Please evaluate this child and complete the remainder of this form.

Diagnosis:_____

_____

Restrictions/Limitations:_____

_____

Treatment_____

Duration_____

Comments_____

_____

_____

_____ _____

Healthcare Provider's Signature Date