

# IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

**Parent/Guardian please complete pages 1 and 2.**

Child's name		Child's birthdate	Name of school
		Grade	School Telephone #
Parent #1 name		Parent #2 name	
Child home address #1			Telephone # 1
Child home address #2			Telephone # 2
Where parent #1 works	Work address	Telephone # Work # Pager # Cellular # Home email Work email	
Where parent #2 works	Work address	Telephone # Work # Pager # Cellular # Home email Work email	
<p><b>In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parents/guardian. <input type="checkbox"/> YES <input type="checkbox"/> NO</b></p> <p><b>During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.</b></p> <p>Parent/Guardian Signature: _____ Date _____</p> <p>Alternate emergency contact person's name: _____ Relationship to child: _____ Phone number: _____</p>			
Child's doctor's name	Doctor telephone #1	Hospital of choice	
Doctor's address	After hours telephone #	Does your child have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Company _____ <b>ID#</b>	
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Company _____ <b>ID#</b>	
Dentist's address	After hours telephone #	<input type="checkbox"/> <b>Please help us find health or dental insurance.</b>  Call: 800-257-8563	
Other medical or dental specialist name	Telephone #	Specialist address:	
<b>Type of specialty</b>			
Mental Health care specialist	Telephone #	Specialist address:	

Child Name: \_\_\_\_\_