

**3<sup>rd</sup>****CHILD'S NAME** \_\_\_\_\_ **Grade in September:** \_\_\_\_\_  
Last FirstDATE OF BIRTH: **Month** \_\_\_\_\_ **Day** \_\_\_\_\_ **Year** \_\_\_\_\_ Gender: **Male** **Female**Is your child's immunization up to date? **YES** **NO****If immunization not up to date state reason:** \_\_\_\_\_

Are there any **special circumstances or information** we should be aware of that would help us work with your child more effectively? Including any hearing, speech, sight, mobility, developmental concerns. (18 stairs to downstairs)

**Medical History of Illness:** Please describe your child's former or current medical history including any medication they currently take.

**ALLERGIES** Does your child have any allergies to the following?

Foods: \_\_\_\_\_

Other: \_\_\_\_\_

Allergy to Medication: \_\_\_\_\_

**Medication Instruction Form Required:** **If your child does have an Epi-Pen or Asthma Inhaler medication and would require medication during his/her time at OSCAR please fill out the Medication Instruction Form** (all medication MUST be in Original Labeled Container) and discuss the specifics with the OSCAR Director. OSCAR staff can only administer medications according to the instructions.

**ASTHMA**Does your child have Asthma? **YES** **NO**

Specify Triggers: \_\_\_\_\_

Location of Inhaler: \_\_\_\_\_

**Medication Form:** **YES** **NO****Epi-Pen**Does your child require an Epi-Pen? **YES** **NO**

Specify Allergy: \_\_\_\_\_

Location of Epi-Pen: \_\_\_\_\_

**Medication Form:** **YES** **NO****Allergy****Treatment:** \_\_\_\_\_

I understand that it is my responsibility to update and inform the OSCAR Child Care Director if there are any changes to **any** of the above address/information/directions/condition for my child named above.

**Parent/Guardian Sign** (any format) \_\_\_\_\_ **Date** \_\_\_\_\_