

LITTLE LIGHTS CHRISTIAN EARLY LEARNING CENTER
15150 Washington Street, Thornton, CO 80023, Phone 720-872-2200

HEALTH STATUS/PHYSICIAN'S STATEMENT

Child's Name: _____ Birth Date: _____

Please provide the required information on your child's health status:

Any current medication: _____

List any allergies and type of reaction: _____

Any diet restrictions? _____

Any chronic health condition? _____

Any concerns with development? _____

I give consent for my child's health care provider and child care provider to discuss my child's health concerns.

Parent/Guardian Signature: _____ Date: _____

* * * * *

**PHYSICIAN'S STATEMENT
TO BE COMPLETED AND SIGNED BY YOUR CHILD'S PHYSICIAN:**

Date of most recent exam: _____ (within the last 12 months or if under 2 years old, 6 months)

Weight _____ Height _____ Vision _____ Hearing _____ Dental _____

Is this child in good health for attending an early childhood learning center? _____

Does this child have an identified health condition or a developmental concern such as seizures, asthma, diabetes, allergies, heart or respiratory condition, and/or physical disability? If so, please provide information and instruction on the care of this child while at our center:

Physician's Name: _____ and Signature _____

Address: _____ Phone: _____

DATE: _____

American Academy of Pediatrics schedule for routine health assessment: (Please circle age for next routine health assessment)
2 months, 4 months, 6 months, 9 months, 12 months, 15-18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 year, 10 years, 12 yr

CURRENT IMMUNIZATION RECORD MUST ALSO BE PROVIDED