illinois action for children
Building Strong Families & Powerful Communities™

Child Care Provider Consent Form

NAME OF CHILD _____

CHILD HOME ADDRESS _____

List the times of the week that the child is in the provider's care.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

(one per child)

EMERGENCY CONTACTS

#1 Name _____ Relationship to Child _____

Primary No. _____ Secondary No. _____

#2 Name _____ Relationship to Child _____

Primary No. _____ Secondary No. _____

EMERGENCY MEDICAL CARE

This authorizes _____ to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement.

_____ is the preferred doctor/clinical hospital.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER PRESCRIPTION and OTC MEDICINE

I/we authorize _____to administer prescribed medicine as specific in the prescription's directions for administration and over-the-counter medicine as specified in written instructions to my/our child.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

TRANSPORTATION

I/we authorize _____ to take my/our children on walking trips, special excursions, and to nearby parks. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the child care provider during the hours of child care.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

HEALTH HISTORY

List any medical problems, past or present, that the child has experienced (illnesses, surgeries, hospitalizations, etc.):

List all immunizations the child has had:

ALLERGY HEALTH CARE PLAN

Allergy to:

Treatment:

Type of allergy transmission: ☐ Ingestion ☐ Contact ☐ Inhalation

Extremely reactive to the following allergens _____

Therefore:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

Epinephrine brand _____ Epinephrine dose ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine brand _____ Antihistamine dose _____

Other (e.g., inhaler-bronchodilator if wheezing) _____ _____

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child