



**Delaware Department of Services for Children, Youth and Their Families**  
**Office of Child Care Licensing**

## Temporary Emergency Child Care Health History Form

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Check the correct answers to the following questions. Give a brief explanation under COMMENTS for any YES answer.

| Does the child have any of the following?   | YES | NO | COMMENTS |
|---|-----|----|----------|
| a) Vision problem?  |     |    |          |
| b) Hearing problem?   |     |    |          |
| c) Speech or language problem?  |     |    |          |
| d) Physical illness or impairment problem?  |     |    |          |
| e) Mental, emotional or behavioral problem?   |     |    |          |
| f) Developmental delay?   |     |    |          |
| g) Allergies?   |     |    |          |
| h) Other? (If YES, specify)   |     |    |          |
| i) Health condition, which may require care or emergency action?<br>(If YES, specify, e.g. seizures, bee sting allergy, diabetes, etc.)<br><b>Attach plan for addressing incidents should they arise.</b> |     |    |          |
| j) Does the child have up to date immunizations?  |     |    |          |
| k) Is the child currently taking any medication?  |     |    |          |

This child is otherwise in good physical and mental health. This child is also free of communicable disease and may participate fully in all activities.

| YES | NO |
|-----|----|
|     |    |

List any areas of the program in which the child cannot fully participate. Would any limits or alterations help to meet his or her needs? Please explain briefly.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_