

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI) _____ Address – Home (Street, City, State, Zip Code) _____

Telephone Number _____ Birthdate (mm/dd/yyyy) _____ Date – First Day of Attendance (mm/dd/yyyy) _____

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
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Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
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PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number
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HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

- Check any special medical condition that your child may have.

<input type="checkbox"/> No specific medical condition <input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral palsy / motor disorder <input type="checkbox"/> Other condition(s) requiring special care – Specify.	<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy / seizure disorder <input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements <input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
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- Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
 Food allergies – Specify food(s).
 Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
- a.
 - b.
 - c.
6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____