

**CHILDREN'S RECORD**  
**Nebraska Health and Human Services System**



**PARENTS: PLEASE FILL IN ALL BLANKS**

Child(ren)'s Name: \_\_\_\_\_ Birthdate(s): \_\_\_\_\_

Enrollment Date: \_\_\_\_\_ Last Enrollment Date: \_\_\_\_\_

**Parent or Guardian's Home Address and Employment Address:**

**FATHER (or Guardian):**

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**MOTHER (or Guardian):**

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Consent to Contact Physician in Emergency:**

In the event I cannot be reached to make arrangements, I hereby give my consent to \_\_\_\_\_  
Caregiver

to contact Doctor \_\_\_\_\_  
Name of Physician Phone

\_\_\_\_\_ and, if necessary, take my child(ren) to the  
Address City

following doctor(s), clinics, or hospital \_\_\_\_\_

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

**Transportation Permission**

I hereby give \_\_\_\_\_ permission to transport or  
Name of Facility

arrange for transportation of my child \_\_\_\_\_  
Name of Child(ren)

I understand staff will insure that my child(ren) is placed in the appropriate safety restraint as indicated by Nebraska law at all times the vehicle is in motion.

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

# Medication Competency Statement

I, \_\_\_\_\_ have determined  
Parent /Guardian Name

\_\_\_\_\_ competent to give or apply medication to my child(ren).  
Provider/Director

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

## CHILD'S MEDICAL INFORMATION

Any health problems which caregiver should know: \_\_\_\_\_

Medication, if any: \_\_\_\_\_

Allergies, if any: \_\_\_\_\_

Special Concerns: (Glasses, Hearing Aid, Crutches) \_\_\_\_\_

Any activities child(ren) should NOT engage in: \_\_\_\_\_

Company providing health and/or accident insurance coverage: (Optional) \_\_\_\_\_

### Certificate of Immunizations

VACCINE	TYPE OF VACCINE	Dose	Normal Schedule	Date Given			DOCTOR OR CLINIC ADMINISTERING
				Mo.	Day	Yr.	
Polio OPV or IPV		1	2 mo.				
		2	4 mo.				
		3	6-18 mo.				
		4	4-6 yrs.				
DTP/DT/DTaP Diphtheria Tetanus Pertussis		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	15-18 mo.				
		5	4-6 yrs.				
Tdap		1	11-18 yrs.				
Td/Tetanus and Diphtheria							
Hib Haemophilus influenzae b		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
M-M-R		1	12-15 mo.				
		2					
Hepatitis A		1					
		2					
Hepatitis B		1					
		2					
		3					
Varicella Chickenpox date of disease		1	12-18 mo.				
		2					
Meningococcal Conjugate		1					
PCV Pneumococcal Conjugate		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
Rotavirus		1	2 mo.				
		2	4 mo.				
		3	6 mo.				

I certify that the above information is correct to the best of my knowledge.

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