DSCYF
Department of Services for Children, Youth & Their Families

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? **(If YES, specify, e.g. seizures, bee sting allergy, diabetes, etc.) Attach plan for addressing incidents should they arise.**			
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