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**Medical Information**

Name of Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Family Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please Complete the Following Questions: Give particulars (please include medication if prescribed with dosage and administering times. Please note that a caregiver can only give medication if it is in the original prescribed container)

|  |  |  |  |
| --- | --- | --- | --- |
| **Does your family member have/had:** | **Yes** | **No** | **If yes, please comment** |
| Allergies (Food) |  |  |  |
| Allergies (Medication) |  |  |  |
| Allergies (Pets/Environmental/others) |  |  |  |
| Significant illness in the past year |  |  |  |
| Ongoing medical problems |  |  |  |
| Physical limitations/Special needs |  |  |  |
| Psychological problems |  |  |  |
| Medication |  |  |  |
| Up to date Immunization |  |  |  |
| Other (please state) |  |  |  |

**CONSENT TO MEDICAL TREATMENT OF CHILDREN**

(Only if the dependent is minor)

I/We \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Primary Parent/Guardian) (Secondary Parent/Guardian)

Hereby authorize the individuals listed in this child care plan to act on my/our behalf to consent to any medical treatment or diagnostic procedures, which may in his/her best judgement be in the best interest of the child listed above. This permission may include the administration of anaesthetics that may be considered necessary or advisable by the attending physician, surgeon, dentist or hospital staff.

Signature of Primary Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Secondary Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sunscreen/Insect Repellent:**

I/We \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Primary Parent/Guardian) (Secondary Parent/Guardian)

hereby authorize the persons listed on my childcare plan to administer sunscreen and/or insect repellent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, if required.

Signature of Primary Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Secondary Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_