Grace Center of Hope, Inc.
912 S. College St
Winchester, TN 37398
gracecentertn@gmail.com

Child's Name: _____ Sex: M F Birth Date: _____ Age:_____

Mother: _____ Father: _____ Guardian: _____

Address: _____ City: _____ Zip:_____

EMERGENCY CONTACTS:

Parent/Guardian's Name: _____ Parent/Guardian's Name: _____

Home Phone Number: _____ Home Phone Number: _____

Work Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Cell Phone Number: _____

Email: _____ Email: _____

Alternative Contact: _____ Alternative Contact: _____

Home Phone Number: _____ Home Phone Number: _____

Work Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Cell Phone Number: _____

EMERGENCY INFORMATION: Consent for Medical Treatment: As the parent/legal guardian, I hereby give consent to the Grace Center of Hope, Inc. to obtain all emergency medical or dental care deemed necessary by a duly licensed physician (M.D.) or dentist (D.D.S.) for (child's name) _____. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Parent/Guardian Signature: _____ Date: _____

Medical Conditions: _____ Physician: _____

Allergies: _____ Address: _____

Current Medications: _____ Phone Number: _____

Dentist: _____ Hospital Desired: _____

Phone Number: _____ Insurance Company: _____

AUTHORIZED INDIVIDUALS TO BRING AND TAKE YOUR CHILD TO AND FROM THE FACILITY:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

HEALTH HISTORY: 1. Past Illnesses: Circle illnesses that your child has had and approximate dates.
Asthma Measles (10 days) Diabetes Mumps Chicken Pox Poliomyelitis Epilepsy Rheumatic Fever Hay Fever Whooping Cough Measles (3 days)

2. Infectious Diseases? No ___ Yes ___ (If yes, please explain)
_____

3. Other Serious/Severe Illness/Accidents? No ___ Yes ___ (If yes, please explain)
_____

4. Does your child have any diet/food restrictions/food allergies? No ___ Yes ___ (If yes, please explain)
_____
_____

5. Is your child diabetic and/or require special medical attention? No ___ Yes ___ (If yes, please explain)
_____
_____

6. What is your overall evaluation of your child's health?
_____
_____

7. Does your child tire easily? No ___ Yes ___ (If yes, please explain)
_____

8. How does your child get along with parents, siblings, and other children?
_____
_____

9. How does your child handle group experiences?

_____

_____

10. Does your child have any special problems (fears, etc.)? No ___ Yes ___ (If yes, please explain)

_____

_____

11. Does your child have any disabilities? No ___ Yes ___ (If yes, please explain)

_____

_____

12. What is your overall evaluation of your child's personality?

_____

_____

13. Comments?

_____

_____