

CACFP Enrollment: Yes:___ No:___

BK___ LN___ SU___ AM Snk___ PM Snk___ Evng Snk___

INSTRUCTIONS TO PARENTS:

- NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.**

Child's Home Address _____

Any Changes/Additional Information _____

(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

Signature of Parent/Guardian _____ Date _____

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____) _____
Telephone Number