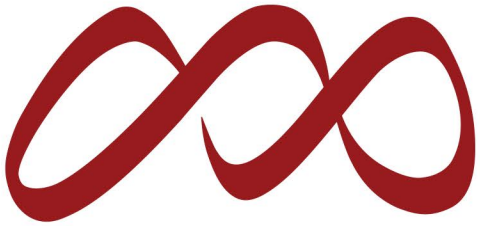

PARK CITY

Little Adventures Children's Center

INFANT HEALTH ASSESSMENT & LIABILITY FORM

Today's Date: _____ Date Child is in our Care: _____

Child's Name: _____ Child's Age: _____ Child's Date of Birth: _____

Parent's Name(s): _____ Phone Number: _____

Address: _____

Email Address: _____

How can you be reached while your child is in our care? _____

Any additional information that will assist our staff in relating to your child such as sibling, pets, favorite toys, songs:

_____

_____

OUT OF AREA/STATE EMERGENCY CONTACT (other than parents):

Name: _____ Phone Number:_____

Address: _____

Relationship to Child: _____

Emergency Contacts in and out of area (other than parents) and persons authorized to pick up the Child

Name	Address	Relationship to Child	Phone #

[ ] Check if there are no emergency contacts available, other than parents.

[ ] Check if there are not persons authorized to pick up the child, other than parents.

WHEN does your infant nap? _____

Are there any special things your baby likes to have when going to sleep? _____

* We put infants on their backs to sleep unless otherwise noted above. *

When did your infant eat last? _____ Next Feeding: _____

Is your infant fed with formula or breast milk? _____

If breast fed, will you be coming in to feed your infant? [ ] Yes [ ] No When? _____

_____

Does your infant eat cereal or baby food? [ ] Yes [ ] No _____

_____

In case of emergency or serious illness, when parents can not be reached immediately, I hereby authorize the provider to obtain medical care and/or provide emergency medical transportation for my child.

Parent Signature: _____ Date: _____

Is your child up to date on his/her immunizations? [ ] No [ ] Yes

What is the name and phone number of your child's doctor?

Name: _____ Phone Number: _____

Does your child have any known allergies or sensitivities to:

	NO	YES	If yes, please list:
Medications			
Foods			
Other			

Illnesses or Medical Conditions

Does your Child have any of the following:

	NO	YES		NO	YES
Asthma			Visual Impairment		
Diabetes			Developmental Delays		
Seizures			Physical Impairment		
Heart Problems			Behavior/Emotional Problems		
Hearing Impairment			Other (explain below)		

Other Illnesses/Medical Conditions

_____

_____

_____

List any regular medications your child takes: _____

*If your child becomes ill, you will be contacted to pick him/her up immediately *

Parent Signature: _____ Date: _____

The health, safety and well being of your child are of upmost importance to us. We will take your children outside for supervised play when we determine, in our sole discretion, that the temperature and conditions are appropriate. We ask that you provide appropriate outdoor attire, including proper footwear, for the season and daily weather conditions in order for your child to participate in daily activities.

FOR MORE INFORMATION CONTACT:
LITTLE ADVENTURES CHILDREN'S CENTER
4000 CANYONS RESORT DR. PARK CITY, UT 84098
RESERVATIONS PHONE: (435) 615-8036
VVAZQUEZ@VAILRESORTS.COM OR AREED1@VAILRESORTS.COM