

FGH

Franklin General Hospital

1720 Central Avenue East
Hampton, Iowa 50441
641-456-5000

Sick Child Program Pre-Registration/Admission Information Checklist

Child's Name _____

Age _____ Birthdate _____

Parent _____

Home Phone _____ Work Phone _____

Relative to Call _____ Phone _____

Past Illnesses _____

Allergies _____

Medications _____ Dosage _____

Diet _____ Favorites _____

Bottle _____

Comments _____

Services and Medication Release

I _____, authorize Franklin General Hospital Sick Child Care (FGH SCC) personnel to administer to _____, my child, any and all medications, services, and procedures as instructed.

I further authorize FGH SCC to care for my child according to their guidelines.

I hereby release FGH, its nurses and employees, and members of the medical staff from any and all liability that might be asserted as a result of the care provided (or not provided) in the Sick Child Care program to my child.

Signed _____ Date _____

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Sick Child Program Nursing Record

Child's Name _____

Child's Illness _____

Allergies _____

Fears _____ Has child ever had a seizure? _____

Instructions for care (lunch, naps, snacks, etc.) _____

May your child be released to anyone other than you? _____ If so, whom _____

Whom to contact in case of emergency _____ Phone _____

Medications _____

Remind parents to please call if they are delayed.

Symptoms during the past 24 hours:

| | | | | | |
|--|-------------|--|------------------------------------|--|-------------|
| | Congestion | | Draining Sinus | | Sore Throat |
| | Cough | | Discharge from eyes, nose, ears | | Vomiting |
| | Convulsions | | | | Other |
| | Diarrhea | | Fever | | |

Observations, Activities, and Medications:

