

# Information Exchange on Children with Health Concerns Form

Dear Health Care Provider:

We are sending you this Information Exchange Form along with a Consent for Release of Information Form (see back) because we have a concern about the following signs and symptoms that we and/or the parents have noted in this child, who is in our care. We appreciate any information you can share with us on this child in order to help us care for him/her more appropriately, and to assist us to work more effectively with the child and family. Thank you!

**To be filled out by Child Care Provider:**

Facility Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

We would like you to evaluate and give us information on the following signs and symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Questions we have regarding these signs and symptoms are: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_ / \_\_ / \_\_ Child Care Provider Signature: \_\_\_\_\_

Child Care Provider Printed Name: \_\_\_\_\_

**To be filled out by Health Care Provider:**

Health Care Provider's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Diagnosis for this child: \_\_\_\_\_

Recommended Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major side effects of any medication prescribed that we should be aware of: \_\_\_\_\_

\_\_\_\_\_

Should the child be temporarily excluded from care, and if so, for how long? \_\_\_\_\_

\_\_\_\_\_

What should we be aware of in caring for this child at our facility (special diet, treatment, education for parents to reinforce your instructions, signs and symptoms to watch for, etc.)?

\_\_\_\_\_

\_\_\_\_\_

Please attach additional pages for any other information, if necessary.

Date \_\_ / \_\_ / \_\_ Health Care Provider Signature: \_\_\_\_\_

Health Care Provider Printed Name: \_\_\_\_\_

## Consent for Release of Information Form

I, \_\_\_\_\_, give my permission for  
(parent/guardian)

\_\_\_\_\_ to exchange health information with  
(sending professional/agency)

\_\_\_\_\_.  
(receiving professional/agency)

This includes access to information from my child's medical record that is pertinent to my child's health and safety. This consent is voluntary and I understand that I can withdraw my consent for my child at any time.

This information will be used to plan and coordinate the care of:

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
(print full name)

Parent/Guardian Signature: \_\_\_\_\_

**Parents or Guardians signing this document have a legal right  
to receive a copy of this authorization.**

Note: In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable California laws, all personal and health information is private and must be protected.

Adapted from : Pennsylvania Chapter of the American Academy of Pediatrics (1993). Model Child Care Health Policies.  
Bryn Mawr: PA: Authors.