

~ Child's Record ~

Admission date: _____ Discharge date: _____

Child's name: _____ Birth date: _____

Address: _____ Home Telephone: _____

Parent or Guardian Information:

1. Name: _____

Address (if different from above): _____

Email address: _____ Home Telephone: _____

Place of employment: _____

Physical address: _____

Work 'phone: _____ Cell 'phone: _____

2. Name: _____

Address (if different from above): _____

Email address: _____ Home Telephone: _____

Place of employment: _____

Physical address: _____

Work 'phone: _____ Cell 'phone: _____

Other Contact Information:

Name, address and telephone number of next-of-kin other than parents:

If parent or guardian cannot be reached by telephone during the time the child is in care, how can he or she be reached?

Name, address and telephone number of a person other than the parent to be contacted in case the parent can't be reached in an emergency:

Names of persons who are permitted to remove the child from the child care facility:

The facility must be notified by the parent or guardian of any changes to the above information as well as when regular transportation or pick-up methods will vary.

Medical Information and Permissions

Name, address, and telephone number of child's physician:

Name, address, and telephone number of family dentist:

Known allergies:

Known medical problems:

Any special needs:

Date of last tetanus shot: _____

Please list here or on an attached sheet of paper any significant factors concerning the child's health, emotions, or living situation that might influence the child's adjustment to this child care facility or that might be important to know when providing a nurturing and supportive environment for him or for her.

I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for child care personnel to obtain whatever treatment may be deemed necessary for

_____ (name of child) born

_____.

This authorization includes my consent for the above-named child to receive treatment by a physician in any hospital emergency department.

Signature of parent or guardian

Date: _____

Signature of witness/care provider

Date: _____