Child's Information/Emergency Form

(Please Print)

Child's Name_____ Date of Birth_____ Age_____ Gender_____
(as of 9/1)

Address_____ Phone _____
Street, City, State, Zip

Parent/Guardian (1) Name_____ Occupation_____

Address (If different than child)_____
Street, City, State, Zip

Home Phone_____ Call Home: ☐ 1st ☐ 2nd ☐ 3rd Cell Phone_____ Call Cell: ☐ 1st ☐ 2nd ☐ 3rd

Work Phone_____ Call Work: ☐ 1st ☐ 2nd ☐ 3rd Email_____

Parent/Guardian (2) Name_____ Occupation_____

Address (If different than child)_____
Street, City, State, Zip

Home Phone_____ Call Home: ☐ 1st ☐ 2nd ☐ 3rd Cell Phone_____ Call Cell: ☐ 1st ☐ 2nd ☐ 3rd

Work Phone_____ Call Work: ☐ 1st ☐ 2nd ☐ 3rd Email_____

Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other (Describe Relationship)_____

Local Emergency Contact (Please list two other than Parent/Guardian)

Emergency Name (1)_____ Relationship_____

Home Phone_____ Call Home: ☐ 1st ☐ 2nd ☐ 3rd Cell Phone_____ Call Cell: ☐ 1st ☐ 2nd ☐ 3rd

Work Phone_____ Call Work: ☐ 1st ☐ 2nd ☐ 3rd

Emergency Name (2)_____ Relationship_____

Home Phone_____ Call Home: ☐ 1st ☐ 2nd ☐ 3rd Cell Phone_____ Call Cell: ☐ 1st ☐ 2nd ☐ 3rd

Work Phone_____ Call Work: ☐ 1st ☐ 2nd ☐ 3rd

Authorized to Pick-Up (Other than Parent/Guardian or Emergency Contacts listed above)

Name_____ Relationship_____

Home Phone_____ Call Home: ☐ 1st ☐ 2nd ☐ 3rd Cell Phone_____ Call Cell: ☐ 1st ☐ 2nd ☐ 3rd

Work Phone_____ Call Work: ☐ 1st ☐ 2nd ☐ 3rd

Child's Physician/Source of Medical Care

Doctor's Name_____ Phone_____

Address_____
Street, City, State, Zip

Local Hospital Preference_____
Name, Address

Health Insurance/Information

Health Insurance Company_____ Group #_____ ID#_____

Does your child have any special physical, educational, emotional, or medical needs? If so, please describe in detail so that our staff can provide the best possible care (all information will remain confidential)

_____

_____

List any allergies and/or reactions (including medications)_____

List any permanent birth marks or other physical markings (ie hemangioma)_____

Does your child get: Frequent Headaches: ☐ Yes ☐ No Frequent Stomachaches: ☐ Yes ☐ No

I hereby give my consent for administration of minor first aid procedures by facility staff. Written consent is given for emergency medical care and transportation to the nearest facility if deemed necessary. I give full authority to act on my behalf in the event you are unable to contact me.

Parent/Guardian Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Director's Signature_____ Date_____