Child's Information/Emergency Form

(Please Print)

Child's Name:_____ Date of Birth:_____ Age: _____ (As of 9/1) Gender: _____

Address:_____ (Street, City, State, Zip) Phone:_____

Parent/Guardian (1) name :_____ Occupation:_____

Address:(if different)_____ (Street, City, State, Zip)

Home Phone:_____ (Circle One for each Number: Call: First Second Third) Business Phone:_____ (Call: First Second Third) Cell #_____ (Call: First Second Third)

Business Address:_____ (Street, City, State, Zip) E-Mail: _____

Parent/Guardian (2) name :_____ Occupation:_____

Address:(if different)_____ (Street, City, State, Zip)

Home Phone:_____ (Circle One for each Number: Call: First Second Third) Business Phone:_____ (Call: First Second Third) Cell #_____ (Call: First Second Third)

Business Address:_____ (Street, City, State, Zip) E-Mail: _____

Child lives with: ○Both parents ○Mother ○Father ○Other (describe relationship) _____

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

Local Emergency Name:_____ Relationship:_____

Home Phone:_____ (Circle One for each Number: Call: First Second Third) Business Phone:_____ (Call: First Second Third) Cell #_____ (Call: First Second Third)

Local Emergency Name:_____ Relationship:_____

Home Phone:_____ (Circle One for each Number: Call: First Second Third) Business Phone:_____ (Call: First Second Third) Cell #_____ (Call: First Second Third)

Authorized to Pick-up (other than Parent/Guardian or Emergency Contacts listed above)

Name:_____ Relationship:_____

Home Phone:_____ (Circle One for each Number: Call: First Second Third) Business Phone:_____ (Call: First Second Third) Cell #_____ (Call: First Second Third)

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:_____ or frequent stomachaches:_____

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's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

ECE Director's Signature _____ Date _____

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