

**PARENTS: PLEASE FILL IN ALL BLANKS**

Child(ren)'s Name: \_\_\_\_\_ Birthdate(s): \_\_\_\_\_

Enrollment Date: \_\_\_\_\_ Updates: \_\_\_\_\_ Date Care Ceased: \_\_\_\_\_

**Parent or Guardian's Home Address and Employment Address:**

**FATHER (or Guardian):**

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

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

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**MOTHER (or Guardian):**

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

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

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Consent to Contact Physician in Emergency:**

In the event I cannot be reached to make arrangements, I hereby give my consent to \_\_\_\_\_

Caregiver

to contact Doctor \_\_\_\_\_

Name of Physician

Phone

and, if necessary, take my child(ren) to the

Address

City

following doctor(s), clinics, or hospital \_\_\_\_\_

Signature of Parent/Guardian

Date

**MEDICATION COMPETENCY STATEMENT**

I, \_\_\_\_\_ have determined

Parent /Guardian Name

that \_\_\_\_\_ is/are competent to give or apply medication to my child(ren).

Provider/Director/Staff Name(s)

Signature of Parent/Guardian

Date

**CHILD'S MEDICAL INFORMATION**

Current health status or any health problems caregiver should know: \_\_\_\_\_

Medication, if any: \_\_\_\_\_

List any allergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: \_\_\_\_\_

Special Concerns: (Glasses, Hearing Aid, Crutches) \_\_\_\_\_

Any activities child(ren) should NOT engage in: \_\_\_\_\_

Company providing health and/or accident insurance coverage: (Optional) \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian

Date