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| **Emergency Contact Information Form** |
| Child’s Name Date of Birth M ☐ F ☐ Non-Binary ☐ |
| Parent’s/Guardian’s Name Parent’s/Guardian’s Name  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Phone |
|
| Address: Address: |
|  |
| City, ST ZIP Code City, ST ZIP Code |
|  |
| Email Address Email Address |
|  |
| **Emergency Contacts**  In the case of an emergency, we always try to contact parent/guardian first. However, we are required to have an emergency contact other than the parent(s). |
| Primary Emergency Contact Secondary Emergency Contact    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Phone |
|
| Address Address |
|  |
| City, ST ZIP Code City, ST ZIP Code |
|  |
| **Additional Pick-up Authorization**  These people are authorized to pick up your child and must show photo ID. |
| Name: Phone number: Relationship: |
| Name: Phone number: Relationship: |
| **Health Permissions and Medical Information Form** |
| Child’s Name: Date: |
| **Allergies**  **\*\* Allergies may require an allergy plan on file prior to program participation\*\*** |
| Does your child have any food allergies? Yes☐ No☐ |
| If you answered yes, please provide details below: |
|  |
|  |
| Is medication needed? If so, explain: |
|  |
| **Medications** |
| Is your child currently taking any medications? Yes ☐ No☐ |
| Please list if applicable: |
|  |
| Special health considerations we should be aware of: |
|  |
| My child may be given prescribed medication with written parent consent Yes ☐ No☐ |
| My child may be given non-prescribed medication with written parent consent Yes ☐ No☐ |
|  |
| Parent’s/Guardian’s Signature Date |
| **Medical Information**  In the event of an emergency, staff members will call 911. The parent or guardian of the child is notified as soon as possible. |
| Hospital/Clinic Preference |
| Physician’s Name Physicians Phone # |
| Insurance Company Insurance Phone # |
| Policy Number |
| **Sick child policy** |
| I understand that if my child becomes ill, I will find alternative care until my child is symptom-free for 24 hours. |
| Parent’s/Guardian’s Signature Date |