Child's Personal Data Sheet

1. Name____DOB_____________

Father's Name_______________________________ Mother's Name_________________________

Home Address____

City _____________________ State___________ ZIP __________ Phone______________________
Father's Employer_______________________ Work Phone______________ Work Hours_________
Mother's Employer______________________ Work Phone______________ Work Hours________
Date enrolled in center__________________________ Date withdrawn from Center______________
Name of Center: **Amazing U Early Learning Center** Clock hours in Care____________

♥♥♥

2. ***Emergency Contact Information***

Name of person to call if parents cannot be reached

Relationship____ Telephone______________________

Address___________________________City______________________ State________ ZIP

Is this person authorized to take the child from the center?

List all other adults who are authorized to take the child from the center:

Name	Relationship	Name	Relationship	Name	Relationship

Address | Address | Address

City State ZIP | City State ZIP | City State ZIP

Telephone | Telephone | Telephone

♥♥♥

3. ***Medical Information***

Child's Physician or emergency treatment facility____Address
City_____________________State_________Phone____

I, ______________________________ Father / Mother / Guardian **(CROSS OUT WORDS THAT DO NOT APPLY)**

of _____________________________ do hereby give my consent to the Director of the Child Care Facility, or his
(Child's Name)
duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

Signed_________________________ Date _________ Witness______________________ Date_______

I hereby give ____ / do not give ___ the Director of the Child Care Facility or his appointed representative permission to give _____ acetaminophen. I understand I will be notified
(Child's Name)
that the medication has been administered.

Signature_____ Date _____

♥♥

4. *Immunizations*: Please Provide a copy of your Child's Immunization Record.

Verified by Health Department Record_____ Physician's Record_____ Other_____

♥♥

5. ***Disease History***: **List the dates of each:**

Measles _____ Mumps_____German Measles_____ Chicken Pox _____ Whooping Cough

___Contracted Tuberculous: Yes_____/No_____ Frequent Ear Infections Yes_____/ No_____

Frequent Throat infection Yes_____/No_____ Defective Heart Yes_____/No_____

Other Conditions or Comments:

_____

♥♥

6. ***Child's developmental needs:***

Physical or emotional problems the child might have:

____**Child's special food needs:** Formula_____ Diabetic diet_____ Allergies_____

Special problems: Medications

_____Allergies _____Temper Tantrums _____ Diabetes_____ Frequent colds _____ Biting_____

Sun Sensitivity_____ Seizures_____ Fainting Spells_____ Bed wetting_____ Other_____

Requires help in: Dressing___ Undressing___ Toileting____ Eating_____ Wash hands _____

Is Child toilet trained? Yes_____/No_____Words used in toileting _____

Favorite: Games_____ Toys_____Food_____

Siblings? Yes_____/No_____ **Name(s) of siblings**: _____

Type of child care used before_____

Other useful information_____

♥♥

7. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signature _____Date _____

♥♥

Additional comments: