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Date enrolled in center__________________________Date withdrawn from Center________________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________________________________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 InfectionsYes____/ 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______Skin__________Medical__________Food____________Temper Tantrums___________

Diabetes___________Frequent colds_________Biting_____________Sun Sensitivity___________

Seizures____Fainting Spells______________Bed wetting_____ Other______________________________

Requires help in: Dressing______Undressing___Toileting_____ Eating____Washing hands_______

Is Child toilet trained? Yes______/No______ Words used in toileting______________________________

Favorite: Games________________________Toys_______________________Foods__________________

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:____

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DCC 503 P(8/97) TECHNICAL ASSISTANCE