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**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

|                       |                                           |
|-----------------------|-------------------------------------------|
| Enrollment Date _____ | Hours & Days of Expected Attendance _____ |
|-----------------------|-------------------------------------------|

|                      |               |      |       |          |
|----------------------|---------------|------|-------|----------|
| Child's Home Address | Street/Apt. # | City | State | Zip Code |
|----------------------|---------------|------|-------|----------|

| Parent/Guardian Name(s) | Relationship | Phone Number(s)               |    |    |
|-------------------------|--------------|-------------------------------|----|----|
|                         |              | Place of Employment:<br>_____ | C: | H: |
|                         |              | W:                            |    |    |
|                         |              | Place of Employment:<br>_____ | C: | H: |
|                         |              | W:                            |    |    |

Name of Person Authorized to Pick up Child (*daily*) \_\_\_\_\_  
Last First Relationship to Child

| Address       |      |       |          |  |
|---------------|------|-------|----------|--|
| Street/Apt. # | City | State | Zip Code |  |
|               |      |       |          |  |

Any Changes/Additional Information

## ANNUAL UPDATES

(Initials/Date)

(Initials/Date)

(Initials/Date)

(Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

| Address | Street/Apt. # | City | State | Zip Code |
|---------|---------------|------|-------|----------|
|---------|---------------|------|-------|----------|

2. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

| Address       |      |       |          |  |
|---------------|------|-------|----------|--|
| Street/Apt. # | City | State | Zip Code |  |

3. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

| Address       |      |       |          |  |
|---------------|------|-------|----------|--|
| Street/Apt. # | City | State | Zip Code |  |

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

| Address       |      |       |          |  |
|---------------|------|-------|----------|--|
| Street/Apt. # | City | State | Zip Code |  |

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_)\_\_\_\_\_  
Telephone Number