GREAT DAYS EARLY EDUCATION CENTER INC

INFORMATION AND AUTHORIZATION FORM

*NAME OF CHILD*_____*DATE*_____
*NICKNAME*_____
*BIRTHDATE*_____ *CHILD'S AGE*_____

Parent(s) or Guardian(s) can be reached during the day.
NAME_____Home Address_____Phone_____
*RELATIONSHIP*_____ *Employer*_____ *Phone*_____
WORK HOURS_____Work Address_____ Phone_____
NAME_____ ____Home Address_____ Phone_____
WORK HOURS_____Work Address_____ Phone_____
◆ *Email address*_____

If Parent or Guardian cannot be reached, contact person:
Name_____Relationship_____ Phone_____
Address_____
Special arrangements_____
Child's Doctor_____Address_____Phone_____
Child's Dentist_____Address_____Phone_____
What hospital do you prefer_____
Child's School_____ Phone_____
Who is authorized to pick up your child
name_____relationship_____Phone_____
Who is authorized to pick up your child
name_____relationship_____Phone_____

PERMISSION IS GIVEN TO THE CHILD CARE FACILITY FOR THE FOLLOWING
A check in the box indicates approval

- ❑ In an emergency, Great Days has my permission to call an ambulance or to take my child to any available physician or hospital at my expense in an emergency. Great Days has my permission to obtain medical treatment for my child, except for these restrictions. List if applicable_____
- ❑ I do not wish my child to receive any medical treatment.
- ❑ My child may be given prescribed medicine Type_____
- ❑ My child may be given non-prescribed medicine Type_____
- ❑ My child may be taken on field trips or excursions by bus or private motor vehicle under required supervision.
- ❑ My child may participate in swimming or other water activity ( ) on site ( ) off site.
- ❑ My child may be photographed for publicity or news purposes

Signature of Parent or Guardian _____Date_____

Has your child had previous experience in Day Care ( ) Yes ( ) No

My hours at the Day Care Program will be:

MONDAY_____ TUESDAY_____ WEDNESDAY_____

THURSDAY_____ FRIDAY _____

Please give only information concerning you child which will help us give better care.

*Briefly describe your child (Physical appearance, personality,abilities)*_____
_____
_____
_____

*Eating Habits and Schedule*_____

*Toilet Habits*_____

*Are you toilet training?*_____*If so what are you doing*_____

*Sleeping Schedule and Habits*_____

*Fears*_____

*Favorite Activities*_____

*Likes and Dislikes*_____
_____
_____

Has your child had : Chicken pox yes( ) no ( )
Does your child have any allergies yes( ) no ( )
Describe:

Are allergies or other health problems serious enough to restrict your child's activities ( ) yes ( ) no Explain:

Other children in household
Name of Child _____*age* _____*sex*_____
*Name of Child*_____*age*_____*sex*_____
*Name of Child*_____*age* _____*sex*_____

*If receiving AFS Case worker' s name*_____