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)*____________________
____
____
____

*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*______________________________