**Child Information Card**

**State of Delaware**

**Department of Services for Children, Youth, and Their Families**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Information** | | | | | |
| Child’s name: | Date of birth: | | Date of enrollment: | Date of discharge: | |
|  |  | |  |  | |
| Child’s address: | | | Hours and days child is scheduled to attend: | | |
|  | | |  | | |
| **Parent/Guardian Information (1)**  Emergency Contact/Authorized to Pick-up Child | | | **Parent/Guardian Information (2)**  Emergency Contact/Authorized to Pick-up Child | | |
| Name: | | | Name: | | |
|  | | |  | | |
| Address, if different from child’s: | | | Address, if different from child’s: | | |
|  | | |  | | |
| Home phone: | Cell phone: | | Home phone: | | Cell phone: |
|  |  | |  | |  |
| Work phone: | Hours of employment: | | Work phone: | | Hours of employment: |
|  |  | |  | |  |
| Employer name and address: | | | Employer name and address: | | |
|  | | |  | | |
| **Additional Emergency Contacts and People Authorized to Pick-up Child** | | | | | |
| Name: | | Address: | | Phone: | |
|  | |  | |  | |
| Name: | | Address: | | Phone: | |
|  | |  | |  | |
| Name: | | Address: | | Phone: | |
|  | |  | |  | |
| **Emergency Medical Care**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment. | | | | | |
| **Transportation**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute. | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of parent/guardian | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | | |
|  | | |  | | |
| **Medical Information** | | | | | |
| Name of child’s physician: | | | Office phone: |  | |
|  | | |  |  | |
| Special medical information, medications, allergies, diet: | | | Health insurance identification information: | | |
|  | | |  | | |
| *The above information is necessary for your child’s protection and this facility is required to have it. Keep this information current.* | | | | | |