IDENTIFICATION AND EMERGENCY INFORMATION

Child Care Centers

To Be Completed by Parent or Authorized Representative

Child's classroom
School year_____
☐ Infant
☐ Toddler
☐ AM Red Preschool
☐ PM Red Preschool
☐ AM Green Preschool
☐ PM Green Preschool

Child_____ Birth Date _____
First Middle Last

Street Address_____ Home Phone_____

City_____ State_____ Zip Code_____

Parent/Guardian 1: Name_____ Relationship _____ Email Address_____

Home Phone:_____ Cell Phone_____ Work Phone_____

Street Address (if different) _____ City_____ State____ Zip Code_____

Parent/Guardian 2: Name_____ Relationship _____ Email Address_____

Home Phone:_____ Cell Phone_____ Work Phone_____

Street Address (if different) _____ City_____ State____ Zip Code_____

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	TELEPHONE	RELATIONSHIP
1.		
2.		
3.		
4.		

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	TELEPHONE	MEDICAL INSURANCE CARRIER/NAME OF INSURED/ POLICY # / /
DENTIST	ADDRESS	TELEPHONE	DENTAL INSURANCE CARRIER/ NAME OF INSURED/POLICY # / /

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

Child will not be allowed to leave with any other person without written authorization from parent or authorized representative

NAME	RELATIONSHIP	NAME	RELATIONSHIP
1.		8.	
2.		9.	
3.		10	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

The above information is essential. If any of the information requested on this form changes, please notify the CCFS office staff immediately.

_____ _____
Signature of Parent, Guardian or Authorized Representative Date

Complete BOTH Sides -->

CONSENT FOR EMERGENCY MEDICAL TREATMENT
Child Care Centers Or Family Child Care Homes

AS THE PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO The Center for Child and Family Studies TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR (child's full name):_____ . THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELLBEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____

_____

_____

_____ _____

DATE PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE SIGNATURE

_____

HOME ADDRESS

_____ _____

HOME PHONE WORK PHONE

_____

CELL PHONE