IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS

To be downloaded, completed and signed by Parent or Authorized Representative

Child's Full Name_____ Date of Birth_____ Sex_____

Child's Street Address_____ Home Phone_____

City_____ State_____ Zip Code_____

Child's Classroom: Blue Room-Part Day
Blue Room-Full Day
AM Red Room

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.		

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.		7.	
2.		8.	
3.		9	
4.		10.	
5.		11.	
6.		12.	

The above information is essential. If any of the information requested on this form changes, please notify the CCFS office staff immediately and come in to the office to make changes on original form.

_____ _____

Signature of Parent, Guardian or Authorized Representative Date

CONSENT FOR EMERGENCY MEDICAL TREATMENT -

Child Care Centers or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Center for Child and Family Studies TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
CHILD'S FULL NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES: _____

_____

_____

PHYSICIAN AND/OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	**ADDRESS**	**TELEPHONE**	**MEDICAL PLAN AND NUMBER**
DENTIST	**ADDRESS**	**TELEPHONE**	**DENTAL PLAN AND NUMBER**

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN _____

_____ _____

DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

Home Address	
Home Phone ( )	Work Phone ( )

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
IS / HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY

WALKED AT MONTHS	BEGAN TALKING AT MONTHS	TOILET TRAINING STARTED AT MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	Dates		Dates		Dates
☐ Chicken Pox ☐ Asthma ☐ Rheumatic Fever ☐ Hay Fever		☐ Diabetes ☐ Epilepsy ☐ Whooping Cough ☐ Mumps		☐ Poliomyelitis ☐ Ten-Day Measles (Rubeola) ☐ Three-Day Measles (Rubella)	

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS		
DOES CHILD HAVE FREQUENT COLDS?	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES

WHAT TIME DOES CHILD GET UP?	WHAT TIME DOES CHILD GO TO BED?	DOES CHILD SLEEP WELL?
DOES CHILD SLEEP DURING THE DAY?	WHEN?	HOW LONG?
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	
	LUNCH	
	DINNER	
WHAT ARE USUAL EATING HOURS?	BREAKFAST	
	LUNCH	
	DINNER	

DAILY ROUTINES, cont.

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?	IF YES, AT WHAT STAGE:	ARE BOWEL MOVEMENTS REGULAR?	WHAT IS USUAL TIME?

WORD USED FOR "BOWEL MOVEMENT"	WORD USED FOR URINATION

PARENT / AUTHORIZED REPRESENTATIVE WHAT IS YOUR EVALUATION OF CHILD'S HEALTH?

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S):	**IF YES, WHAT KIND**	**DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?**	**IF YES, WHAT KIND:**

PARENT / AUTHORIZED REPRESENTATIVE WHAT IS YOUR EVALUATION OF CHILD'S PERSONALITY?
HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, BROTHERS, SISTERS AND OTHER CHILDREN?
HAS THE CHILD HAD GROUP PLAY EXPERIENCES?
DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)
WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?
REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

Early Childhood Lab School

Child and Family Information

Welcome to a new lab school year. The information requested here will help this year's teaching staff begin to become acquainted with your child and family. You will be able to discuss additional developmental information and questions during the teachers' home visit prior to the beginning of school.

We encourage you to be open, detailed, and transparent about your child's individual strengths and challenges. This information you share with our teaching staff allows us to better design an engaging and appropriate program for your child.

To protect your family's privacy this form will remain in your child's confidential file and will accessed only by the professional ECL staff.

Date:	
Child's full name:	Child's birth date:
Child's preferred name (if different):	Child's gender:

Child's Parents/Guardians: indicate which parent is completing this form: ☐ P/G1 ☐ P/G2

Parent/Guardian 1	**Parent/Guardian 2**
Full name	Full name
Age	Age
Occupation and employer	Occupation and employer
Educational level attained	Educational level attained
Major/Specialty	Major/Specialty
Lives in child's home?	Lives in child's home?

Child's Siblings

Name	Birthdate	Living in household?	Attends/attended ECL?	School/Grade

Is there anyone else living in child's household? ☐ Yes ☐ No If yes, who?
Are parents living together? ☐ Yes ☐ No If no, to whom should correspondence be addressed?
Please describe any pertinent legal or physical custody arrangements or visitation schedules: attach additional pages as necessary.
Please describe any additional childcare/educational arrangements for your child for the upcoming school year:
Please describe your child briefly. Do they have any special interests? What makes them happy? What is hard for them?

Has your child had any serious illness, operations, injuries, or health issues that might affect program attendance or activity? ☐ Yes ☐ No

If yes, please explain:

Explain any concerns you may have about your child's development:

Has your child been screened for any delays or differences? ☐ Yes ☐ No

If yes, which?

Please list any medical, behavioral, psychological, or academic diagnoses that your child may have. If you have any diagnostic reports, IFSPs, or IEPs, we encourage you to include copies with this form so that we may work together to provide the best possible support for your child.

Optional Demographic Information

Any information you provide in this section will be used to help us design a program that is sensitive to your family's home culture and identity. It will remain confidential and will not be used in a discriminatory manner.

X		*Details:*
X	Child with special rights or learning disabilities	
	Racial identity	
	Cultural identity	
	Ethnic or national origin	
	Religious identity	
	LGBTQ family	
	Single parent family	
	Adopted family	
	Foster family	
	Other:	

INSTRUCTIONS TO COMPLETE AND SUBMIT:

This ECL enrollment form containing medical or sensitive data is to be completed and signed. You may print it out and mail it to CCFS. Or you may upload it to a secure site using the below link after saving it to your computer using your child's first and last names and the school year, i.e. *JonahSmith23-24.pdf* SAVE AS (Rename Document) UPLOAD

The Physician's Report found on the ECL forms webpage *https://ccfs.ucdavis.edu/ecl/enrollment-forms* must be printed and brought to your child's health provider for completion**.** You may also scan and upload it to the above secure site. Go to ECL forms webpage

To submit hard copies, mail (anytime) to:
CCFS
One Shields Ave
Davis, CA 95616-5270

Or bring to CCFS office when it reopens on August 28
238 1st Street (between A and B Streets)
Davis, CA

Do not email these documents as they contain sensitive information.

FORMS ABOVE:

- *Identification and Emergency Information*
- *Consent for Emergency Medical Treatment*
- *Child's Preadmission Health History-Parent's Report*
- *Child and Family Information*