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 <u>BOTH</u> Sides -->

PERMISSIONS FORM

CCFS Early Childhood Lab School

ALL questions must be completed.

Child's Full Name____

Child's Classroom/School Year_____________________/____________

- **Field Trip Consent**: See Parent Handbook page 12.
  I give permission for my child to participate in excursions (walking or in buggies) to nearby sites. These will be led and supervised by ECL Staff. Notice about each walking trip will be posted for parents ahead of time.

  Initial________

- **Photo Consent**:
  I grant permission to the Early Childhood Laboratory and to those acting with its permission to include photographs of my child in educational and informational materials as described in the Parent Handbook. I understand that I have no ownership interest in the photograph(s) or materials in which they are included and that I will not receive payment of any kind for their use. I understand that my child's name will not be used (except for *first* name references in classroom newsletters). I release the ECL and its assignees from any claims arising from the use of such photographs.

  Initial________

- **Family Directory**: In order to build community and give families a chance to get to know one another outside the program, we distribute a paper copy of the ECL Family Directory soon after school begins. The information will reflect your preferences below. **Unless otherwise requested the Family Directory will include by classroom the child's and parent(s) first names and the following: (i**ndicate what you would like published - please **print clearly**):

  Parent 1 first name or nickname ____
  P1 preferred phone ____
  P1 preferred email ____
  Parent 2 first name or nickname ____
  P2 preferred phone ____
  P2 preferred email ____

- **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: ______________________________________or none _____

  Initial________

I, as parent/guardian, give my permission as described above and in accordance with the conditions stated here. I understand that by giving these permissions, I have waived all claims against the University, its employees, or the State of California for injury, accident, illness or death.

____ ________ ____________________

Parent, Domestic Partner or Authorized Representative Signature Date

Print Name____

Complete BOTH Sides -->