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| --- |
| **Emergency Contact Information Form**  |
|  Child’s Name Date of Birth M ☐ F ☐ Non-Binary ☐   |
|  Parent’s/Guardian’s Name Parent’s/Guardian’s Name  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Phone |
|
|  Address: Address:  |
|   |
|  City, ST ZIP Code City, ST ZIP Code  |
|   |
|  Email Address Email Address  |
|  |
| **Emergency Contacts** In the case of an emergency, we always try to contact parent/guardian first. However, we are required to have an emergency contact other than the parent(s).  |
|  Primary Emergency Contact Secondary Emergency Contact  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Phone   |
|
|  Address Address  |
|   |
|  City, ST ZIP Code City, ST ZIP Code  |
|   |
| **Additional Pick-up Authorization**These people are authorized to pick up your child and must show photo ID.  |
| Name: Phone number: Relationship:  |
| Name: Phone number: Relationship:  |
|  **Health Permissions and Medical Information Form**  |
| Child’s Name: Date:  |
| **Allergies** **\*\* Allergies may require an allergy plan on file prior to program participation\*\***  |
| Does your child have any food allergies? Yes☐ No☐  |
| If you answered yes, please provide details below:  |
|   |
|   |
| Is medication needed? If so, explain:  |
|   |
| **Medications**  |
| Is your child currently taking any medications? Yes ☐ No☐  |
| Please list if applicable:  |
|   |
| Special health considerations we should be aware of:  |
|   |
| My child may be given prescribed medication with written parent consent Yes ☐ No☐  |
| My child may be given non-prescribed medication with written parent consent Yes ☐ No☐  |
|    |
| Parent’s/Guardian’s Signature Date  |
| **Medical Information** In the event of an emergency, staff members will call 911. The parent or guardian of the child is notified as soon as possible.  |
| Hospital/Clinic Preference  |
| Physician’s Name Physicians Phone #  |
| Insurance Company Insurance Phone #  |
| Policy Number  |
| **Sick child policy**  |
| I understand that if my child becomes ill, I will find alternative care until my child is symptom-free for 24 hours.   |
| Parent’s/Guardian’s Signature Date  |