Child's Personal Data Sheet

1. Name____DOB____________

Father's Name_______________________________ Mother's Name________________________

Home Address____

City ______________________________ State__________ ZIP __________ Phone__________

Father's Employer____________________ Work Phone______________ Work Hours________

Mother's Employer____________________ Work Phone______________ Work Hours________

Date enrolled in center_________________________ Date withdrawn from Center____________

Name of Center______________________________ Clock hours in Care_______________

2. ***Emergency Contact Information***

Name of person to call if parents cannot be reached_________________________________

Relationship_______________________________________ Telephone____________________

Address_________________________City_____________________ State________ ZIP______

Is this person authorized to take the child from the center?____________________________

List all other adults who are authorized to take the child from the center:

Name Relationship	Name Relationship	Name Relationship
Address	Address	Address
City State ZIP	City State ZIP	City State ZIP
Telephone	Telephone	Telephone

3. ***Medical Information***

Child's Physician or emergency treatment facility____

Address______________________City_____________________State_________Phone__________

I, ___________________________ Father / Mother / Guardian **(CROSS OUT WORDS THAT DO NOT APPLY)** of

___________________________ do hereby give my consent to the Director of the Child Care Facility, or his
(Child's Name)

duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

Signed__________________________ Date __________ Witness_______________________ Date____

I hereby give ____ / do not give ____ the Director of the Child Care Facility or his appointed representative permission to give ______________________________ acetaminophen. I understand I will be notified that the medication has been administered.

(Child's Name)

Signature ____ Date ____________

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4. ***Immunizations*: Please Provide a copy of your Child's Immunization Record.**

Verified by Health Department Record_______ Physician's Record________ Other_____________

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5. ***Disease History*: List the dates of each:**

Measles ________ Mumps_______ German Measles_______ Chicken Pox __________ Whooping Cough _________

Contracted Tuberculous: Yes_____/No______

Frequent Ear Infections Yes______/No______

Frequent Throat infection Yes_____/No_______

Defective Heart Yes_____/No______

Other Conditions or Comments____

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6. ***Child's developmental needs:***

Physical or emotional problems the child might have: ______________________________

Child's special food needs: Formula_________ Diabetic diet__________ Allergies_____________________

Special problems: Medications____

Allergies __________________ Temper Tantrums _____ Diabetes______ Frequent colds _______ Biting________

Sun Sensitivity_________ Seizures__________ Fainting Spells__________ Bed wetting___________ Other________

Requires help in: Dressing___ Undressing___ Toileting____ Eating____ Washing hands______

Is Child toilet trained? Yes_____/No______ Words used in toileting__________________________

Favorite: Games_____________________ Toys_____________________ Foods_____________

Siblings? Yes_____/No______ **Name(s) of siblings:** ______________________________

Type of child care used before____

Other useful information____

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7. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

______________________________ Signature

______________ Date

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Additional comments:____