

Child's Personal Data Sheet

1. Name _____ DOB _____

Father's Name _____ Mother's Name _____

Home Address _____

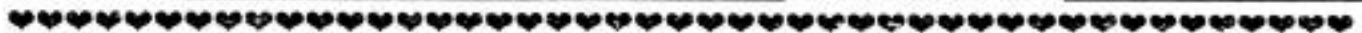
City _____ State _____ ZIP _____ Phone _____

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Date enrolled in center _____ Date withdrawn from Center _____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 _____	Address _____	Address _____	Address _____
City _____ State _____ ZIP _____	City _____ State _____ ZIP _____	City _____ State _____ ZIP _____	City _____ State _____ ZIP _____	City _____ State _____ ZIP _____	City _____ State _____ ZIP _____
Telephone _____	Telephone _____	Telephone _____	Telephone _____	Telephone _____	Telephone _____



3. Medical Information

Child's Physician or emergency treatment facility _____

Address _____ City _____ State _____ Phone _____

I, _____
Father
Mother (CROSS OUT WORDS THAT DO NOT APPLY) of
Guardian

_____ (Child's Name) do hereby give my consent to the Director of the Child Care Facility, or his 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
(Child's Name)
that the medication has been administered.

Signature _____ Date _____

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

Verified by Health Department Record _____ Physician's Record _____ Other _____

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 _____

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 _____ Cries _____
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 _____

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

Signature _____ Date _____

Additional comments: _____