

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

| | | | | | |
|--|-----------|--------|-------|---------------------------|---------------------------|
| CHILD'S NAME | LAST | MIDDLE | FIRST | SEX | TELEPHONE () |
| ADDRESS | NUMBER | STREET | CITY | STATE | ZIP |
| | | | | | BIRTHDATE |
| FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME | LAST | MIDDLE | FIRST | BUSINESS TELEPHONE () | |
| HOME ADDRESS | NUMBER | STREET | CITY | STATE | ZIP |
| | | | | | HOME TELEPHONE () |
| MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME | LAST | MIDDLE | FIRST | BUSINESS TELEPHONE () | |
| HOME ADDRESS | NUMBER | STREET | CITY | STATE | ZIP |
| | | | | | HOME TELEPHONE () |
| PERSON RESPONSIBLE FOR CHILD | LAST NAME | MIDDLE | FIRST | HOME TELEPHONE () | BUSINESS TELEPHONE () |

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

| NAME | ADDRESS | TELEPHONE | RELATIONSHIP |
|------|---------|-----------|--------------|
| | | | |
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| | | | |
| | | | |

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

| | | | |
|-----------|---------|-------------------------|------------------|
| PHYSICIAN | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE () |
| DENTIST | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE () |

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

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

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 |
|------|--------------|
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| | |

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION

DATE LEFT

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

Temple Isaiah Preschool _____ 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
NAME

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

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
()

WORK PHONE
()