

# IDENTIFICATION AND EMERGENCY INFORMATION

## CHILD CARE CENTERS

To Be Completed by Parent or Guardian

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
FATHER'S NAME	LAST	MIDDLE	FIRST	BIRTHDATE	BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S NAME	LAST	MIDDLE	FIRST	BIRTHDATE	BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
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

### 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 GUARDIAN)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT OR GUARDIAN	DATE
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### TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR

DATE OF ADMISSION	DATE LEFT
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# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

\_\_\_\_\_ TO PROVIDE 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 WHATEVER  
NAME  
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

( )