**Keep one copy of this form in the family file and one copy with your classroom’s First Aid Kit.**

**Is anyone legally restricted from being in contact with your child?** [ ]  **Yes** [ ]  **No If yes, name of person(s):­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Staff: request copy of legal documentation)**

|  |  |
| --- | --- |
|  | Child’s Name: Click here to type. |
|  | Date of Birth: Click here to type. |
| **Photo of Child** | Center/Site Name: Click here to type. |
| **(Optional)** | Child’s Home Address (House/Apt#, Street, City, Zip): Click here to type. |
|  | Transportation:[ ]  Car/Walk[ ]  Bus **(if applicable to your program- Staff: Write bus information when available):** |  |
|  | **Parent/Guardian 1** | **Parent/Guardian 2** |
| Name: | Click here to type. | Click here to type. |
| Relationship to Child: | Click here to type. | Click here to type. |
| Primary Language(s): | Click here to type. | Click here to type. |
| Interpreter Needed? | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Phone Number: | Click here to type. [ ]  Cell [ ]  Home [ ]  Work | Click here to type. [ ]  Cell [ ]  Home [ ]  Work |
| Alternate Phone Number: | Click here to type. [ ]  Cell [ ]  Home [ ]  Work | Click here to type. [ ]  Cell [ ]  Home [ ]  Work |
| Email Address: | Click here to type. | Click here to type. |
| When is the best time to reach you? | [ ]  Mornings [ ]  Afternoons[ ]  Evenings [ ]  Anytime | [ ]  Mornings [ ]  Afternoons[ ]  Evenings [ ]  Anytime |
| What is the best way for us to communicate with you? | [ ]  Note in child’s backpack [ ]  Phone Call[ ]  Text [ ]  Email [ ]  Face-to-Face | [ ]  Note in child’s backpack [ ]  Phone Call[ ]  Text [ ]  Email [ ]  Face-to-Face |
| Where would you prefer to meet for family support visits and parent teacher conferences? | [ ]  Home [ ]  Center[ ]  Other – **Discuss the specific place with the staff:** | [ ]  Home [ ]  Center[ ]  Other – **Discuss the specific place with the staff:** |

|  |  |
| --- | --- |
| Name of Emergency Contact: Click here to type. | Relationship to Child: Click here to type. |
| City and State: Click here to type. | Phone: Click here to type. [ ]  Cell [ ]  Home [ ]  Work |

|  |  |
| --- | --- |
| Child’s Health Care Provider/Preferred Facility: Click here to type. | Phone: Click here to type. [ ]  Cell [ ]  Home [ ]  Work |
| Medical Conditions/Allergies, if any: Click here to type. | Medications: Click here to type. |
| Child’s Insurance: Click here to type. | Insurance ID #: Click here to type. |

|  |  |
| --- | --- |
| Child’s Dentist: Click here to type. | Phone: Click here to type. [ ]  Cell [ ]  Home [ ]  Work |

|  |
| --- |
| Child’s Child Care Provider, if applicable: Click here to type. |
| Address (Building/House #, St, City, Zip): Click here to type. | Phone: Click here to type. [ ]  Cell [ ]  Home [ ]  Work |

|  |
| --- |
| **Authorized to be released to/to pick up –** People listed below must show proper identification before your child will be released from the center or the bus. No child will be released to a person under the age of 18 regardless of whether the local school district/agency allows for release to a younger person.**I give permission for my child to be released to the following people for the current program year.**  |
| **Name** | **Relationship to Child** | **Phone Number** |
| Click here to type. | Click here to type. | Click here to type. |
| Click here to type. | Click here to type. | Click here to type. |
| Click here to type. | Click here to type. | Click here to type. |
| Click here to type. | Click here to type. | Click here to type. |
| Click here to type. | Click here to type. | Click here to type. |
| Click here to type. | Click here to type. | Click here to type. |
| Click here to type. | Click here to type. | Click here to type. |
| Click here to type. | Click here to type. | Click here to type. |

**If initialed, this means I give consent for the following while my child is enrolled in this Daycare Program.**

**Consent for Services**

\_\_\_\_\_ Transportation to/from the center, when/if available

\_\_\_\_\_ Access to and retention of State Child Profile immunization record

\_\_\_\_\_ Photograph/video to help train staff

\_\_\_\_\_ Photograph/video to build partnerships with community agencies

\_\_\_\_\_ Use of interpreter (if applicable)

**For your child’s safety,** your signature below grants trained staff permission to provide your child with emergency treatment including First Aid and CPR. When deemed immediately necessary, medical surgical and hospital care, treatment, and procedures will be provided by your child’s regular health care provider, or by a licensed physician or hospital, if your regular health care provider cannot be reached. If you cannot be reached, transportation will be provided by ambulance, aid car, or by any of the people named above to an emergency center for treatment.

Parent/Guardian Signature:­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_