CHILD NAME (LAST)	(FIRST)		(MIDDLE)
HOME PHONE	DATE OF BIRTH	GENDER	CUSTODY CONCERNS ☐NO ☐YES (IF YES, CONTACT DAY CARE)
HOME ADDRESS	ADDITIONAL MAILING ADDRESS		LANGUAGE SPOKEN AT HOME

NAME OF RESPONSIBLE ADULT (LAST, FIRST, MI)		NAME OF RESPONSIBLE ADULT (LAST, FIRST, MI)	
WORK PHONE (EXT)	CELL PHONE	WORK PHONE (EXT)	CELL PHONE
EMAIL		EMAIL	
RELATIONSHIP TO STUDENT ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER (SPECIFY)		RELATIONSHIP TO STUDENT ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER (SPECIFY)	

IF PARENT CANNOT BE REACHED, PERSON AUTHORIZED TO PICK UP OR BE CONTACTED IN CASE OF AN EMERGENCY		
NAME		
ADDRESS		
PHONE (EXT)	PHONE (EXT)	EMAIL
RELATIONSHIP TO STUDENT ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER (SPECIFY)		

IF PARENT CANNOT BE REACHED, ADDITIONAL PERSON AUTHORIZED TO PICK UP OR BE CONTACTED IN CASE OF AN EMERGENCY	
NAME	ADDRESS
PHONE (EXT)	CELL PHONE
EMAIL	
RELATIONSHIP TO STUDENT ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER (SPECIFY)	

Day Care Staff will administer first aid and/or take your child to a physician or hospital for emergency treatment in the event it appears necessary and neither parent (guardian) can be contacted	
PHYSICIAN NAME	PHYSICIAN PHONE
DENTIST NAME	DENTIST PHONE
HOSPITAL PREFERENCE	
ALLERGIES – MEDICATIONS	
ALLERGIES – BEE STINGS ☐NO ☐YES ADDITIONAL INFORMATION	
ALLERGIES – OTHER	
CURRENTLY PRESCRIBED MEDICATIONS	
OTHER CONCERNS	
HEALTH INSURANCE ☐NO ☐YES INSURANCE PROVIDER NAME	GROUP NO.
DOES THE CHILD HAVE A HEALTH CONDITION REQUIRING POSSIBLE EMERGENCY CARE? ☐NO ☐YES (SPECIFY)	

Printed Parent/Guardian Name	Signature of Parent/Guardian	Date