§1515.A.1,2,3

Admit Date: _____

Child's Information Form

Child's Name: _____ Sex _____ Birthdate _____

	Mother	Father
Name		
Address		
Employer		
Home Phone#		
Work Phone#		
Cellular Phone#		

Person with whom the child lives: _____
Child's Doctor: _____ Doctor's Phone #: _____
Child's Dentist: _____ Dentist's Phone #: _____

Individuals to contact in case of an emergency:
_____ Phone#: _____
_____ Phone#: _____
_____ Phone#: _____
_____ Phone#: _____

Does your child have any food allergies?	Yes	No
Does your child have any other allergies?	Yes	No
Does your child have any dietary restrictions?	Yes	No
Does your child have any special needs or health concerns?	Yes	No

Please explain any "yes" answer here:

_____
_____
_____

My child has permission to be released to the following individuals, child care facilities or transportation services in addition to emergency contact persons listed above.
(Please notify these individuals that they may be asked to show proof of identity)

Name(First and Last)	Relationship

I authorize the facility to secure emergency medical treatment for my child.

Parent's Signature:_____ Date: _____