FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

EMERGENCY AND IDENTIFICATION INFORMATION

(This information also needs to be current with your provider)

Parent/Guardian Information:

Mother's/Guardian's Name_____ DOB_____
Home Phone_____ Work Phone _____
E-mail Address _____
Have you received cash aid in the last two years? Yes / No If yes indicate last date received _____

Second Parent/Guardian Information:

Is the Second Parent/Guardian of any of the children in the home? **Yes / No (please circle one)**
If yes please complete below info:
Second Parent/Guardian's Name:_____ DOB_____
Social Security Number_____

***** We Do Not Pay for In-Home Child Care *****

Children Under the age of 13

Child's Name_____ DOB_____
Ethnicity_____ Native Language_____ Special Needs? Yes/No (please circle one)
School_____ School Hrs _____to_____ Min Day_____to_____ M T W Th F
Traditional____ or Track_____(indicate track) Grade_____ School District_____
Does this child need child care services? Yes / No (please circle one)
Name of Child Care Provider _____
Medical Insurance #_____ List any Allergies or Medical Limitations_____
Physician's Name:_____ Physician's Phone: _____

Child's Name_____ DOB_____
Ethnicity_____ Native Language_____ Special Needs? Yes/No (please circle one)
School_____ School Hrs _____to_____ Min Day_____to_____ M T W Th F
Traditional____ or Track_____(indicate track) Grade_____ School District_____
Does this child need child care services? Yes / No (please circle one)
Name of Child Care Provider _____
Medical Insurance #_____ List any Allergies or Medical Limitations_____
Physician's Name:_____ Physician's Phone: _____

***** Space for Additional Children on Back *****

Persons authorized to contact and take child/children from child care facility. The child will not be allowed to leave with any other person without written authorization.

Name Phone # Relationship
1) _____
2)_____

If a physician cannot be reached, what action should be taken? _____

Permission for medical treatment: Administrative procedures vary among medical personnel and medical facilities with regards to medical care for a child in the absence of a parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance.

Signature _____ Date _____

ADDITIONAL CHILDREN

Child's Name_____ DOB_____
Ethnicity_____ Native Language_____ Special Needs? Yes/No (please circle one)
School_____ School Hrs _____to_____ Min Day_____to_____ M T W Th F
Traditional____ or Track_____(indicate track) Grade_____ School District_____
Does this child need child care services? Yes / No (please circle one)
Name of Child Care Provider _____
Medical Insurance #_____ List any Allergies or Medical Limitations_____
Physician's Name:_____ Physician's Phone: _____

Child's Name_____ DOB_____
Ethnicity_____ Native Language_____ Special Needs? Yes/No (please circle one)
School_____ School Hrs _____to_____ Min Day_____to_____ M T W Th F
Traditional____ or Track_____(indicate track) Grade_____ School District_____
Does this child need child care services? Yes / No (please circle one)
Name of Child Care Provider _____
Medical Insurance #_____ List any Allergies or Medical Limitations_____
Physician's Name:_____ Physician's Phone: _____

Child's Name_____ DOB_____
Ethnicity_____ Native Language_____ Special Needs? Yes/No (please circle one)
School_____ School Hrs _____to_____ Min Day_____to_____ M T W Th F
Traditional____ or Track_____(indicate track) Grade_____ School District_____
Does this child need child care services? Yes / No (please circle one)
Name of Child Care Provider _____
Medical Insurance #_____ List any Allergies or Medical Limitations_____
Physician's Name:_____ Physician's Phone: _____

Child's Name_____ DOB_____
Ethnicity_____ Native Language_____ Special Needs? Yes/No (please circle one)
School_____ School Hrs _____to_____ Min Day_____to_____ M T W Th F
Traditional____ or Track_____(indicate track) Grade_____ School District_____
Does this child need child care services? Yes / No (please circle one)
Name of Child Care Provider _____
Medical Insurance #_____ List any Allergies or Medical Limitations_____
Physician's Name:_____ Physician's Phone: _____

Please List all other children in the home between the ages of 13-18
Name_____ DOB:_____
Name_____ DOB:_____
Name_____ DOB:_____
Name_____ DOB:_____