



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: \_\_\_\_\_  
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Name \_\_\_\_\_ DOB: \_\_\_\_\_