First day at Smarties Early Learning Center\_\_\_\_\_\_\_

**Child Emergency Information**

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| --- |
| Child's Full Name : Date of Birth: |
| Parent/Guardian Name: |
| Relationship to child: |
| Home Address |
| Home phone: Cell phone: |
| Employer/School: |
| Work/School phone: E-mail: |
| Where can you be reached most of the time when your child is at this program? |
| Parent/Guardian Name:  Relationship to child: |
| Home Address |
| Home phone: Cell phone: |
| Employer/School: |
| Work/School phone: E-mail |
| Where can you be reached most of the time when your child is at this program? |
| Emergency Contact Person (Other than parent/guardian):  Name:  Phone #: Relationship: |
| Authorized pick-up persons: |
| Name: Relationship: Phone #: |
| Name: Relationship: Phone #: |
| Name: Relationship: Phone #: |
| Emergency Transportation |
|  |
| I give Smarties Early Learning Center |
| my permission to have my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| transported to (Hospital, Clinic) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for emergency medical care or to |
| (Dentist - if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for emergency dental care. |
|  |
| Parent's Signature: |
| Date: |
|  |
| Name of Physician:  or Clinic/Hospital (if applicable) |
| Telephone number: |
|  |
| Name of Dentist: |
| Telephone Number |
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|  |
| |  | | --- | | Parent Roster | | I agree to have my Name and Telephone Number included on my child's class roster list which will be made available upon request to any parent whose child is enrolled in the center. | |  | | Parent / Guardian Signature: | |
| Child Health and Enrollment Information |
| Child's Name: |
| Date form completed/updated: |
| Health Information: |
| Allergies (food, medication, & environmental) and precautions, reactions, and treatment: |
| Medicines, food supplements, modified diet currently being administered: |
| Chronic Physical Problems: |
| History of Hospitalization: |
| History of diseases the child has had: |
| Any additional health or enrollment information you feel we should know about your child: |
| Any developmental concerns or questions regarding your child? |
| Immunization Records  Please provide a copy from your child’s physician (within 2 weeks of start date) |
|  |
| When your child has shots, please provide us with an updated copy of his/ her records. |