



Division of Public Health - Licensure Unit - Children's Services Licensing Program
Children's Record

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name: _____ Birthdate(s): _____

Enrollment Date: _____ Updates: _____ Date Care Ceased: _____

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: _____ Employer: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

MOTHER (or Guardian):

Name: _____ Employer: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Consent to Contact Physician In Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to _____

Caregiver

to contact Doctor _____

Name of Physician

Phone

and, if necessary, take my child(ren) to the

Address

City

following doctor(s), clinics, or hospital _____

Signature of Parent/Guardian

Date

MEDICATION COMPETENCY STATEMENT

I, _____ have determined

Parent/Guardian Name

that _____ is/are competent to give or apply medication to my child(ren).

Provider/Director/Staff Name(s)

Signature of Parent/Guardian

Date

CHILD'S MEDICAL INFORMATION

Current health status or any health problems caregiver should know: _____

Medication, if any: _____

List any allergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: _____

Special Concerns: (Glasses, Hearing Aid, Crutches) _____

Any activities child(ren) should NOT engage in: _____

Company providing health and/or accident insurance coverage: (Optional) _____

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian

Date