EARLY CHILDHOOD CENTER/ KIDSPLACE HEALTH INFORMATION FORM

NOTE: THIS SIDE TO BE COMPLETED BY PARENT, **NOTARIZED** AND RETURNED TO THE PRE-SCHOOL OFFICE.

CHILD'S LAST NAME:_____FIRST_____SEX_____DATE OF BIRTH_____

ADDRESS _____TOWN/ZIP _____HOME PHONE _____

EMERGENCY CONTACT 1._____ PHONE_____

2. _____ PHONE_____

PHYSICIAN'S NAME_____ PHONE_____

PARENT (1) _____ CELL _____ WORK #_____

PARENT (2)_____ CELL_____ WORK # _____

BROTHERS AND SISTERS, LIST NAMES & AGES_____

OTHERS LIVING WITH FAMILY (RELATIONSHIP) _____

PARENTS: MARRIED_____ DIVORCED_____ SEPARATED_____

IS CHILD TOILET TRAINED?_____

HAS CHILD BEEN IN ANY GROUP SITUATION AWAY FROM HOME BEFORE?_____

DID CHILD ENJOY THE EXPERIENCE?_____

IS THERE ANY ADDITIONAL INFORMATION THAT WOULD BE OF HELP TO THE TEACHER/COUNSELOR WORKING WITH YOUR CHILD? _____

IS THERE ANY ADDITIONAL ***MEDICAL*** INFORMATION THAT WOULD BE OF HELP TO THE TEACHER/COUNSELOR WORKING WITH YOUR CHILD? _____

LIST ALL ALLERGIES:_____

AUTHORIZATION FOR EMERGENCY MEDICAL - SURGICAL TREATMENT (Please read *carefully*.)

NOTE: IT IS THE FIRM HOPE THAT THE AUTHORIZATION GRANTED ON THIS FORM WILL NEVER HAVE TO BE USED. FOR THE SAFETY OF THE CHILD, HOWEVER, SOUND MEDICAL PRACTICE CALLS FOR SUCH AUTHORIZATION. EMERGENCY SITUATIONS WHERE, FOR SOME REASON, THE PARENTS, EMERGENCY NAMES OR PEDIATRICIAN CANNOT BE CONTACTED IMMEDIATELY, THIS FORM MAY BE EXTREMELY IMPORTANT. THE AUTHORIZATION GRANTED BY THIS FORM WILL BE USED ONLY WHERE ABSOLUTELY NECESSARY AND ONLY AFTER EVERY ATTEMPT HAS BEEN MADE TO CONTACT THE PARENTS, EMERGENCY NAMES OR CHILD=S PEDIATRICIAN. DOCTORS AND HOSPITALS REFUSE TO GIVE ANY TREATMENT, REGARDLESS OF HOW MINOR, UNLESS THEY HAVE **NOTARIZED** AUTHORIZATION FROM A PARENT.

IF AFTER REASONABLE ATTEMPTS HAVE BEEN MADE TO REACH THE ABOVE NAMED INDIVIDUALS AND THEY CANNOT BE CONTACTED, THEN I HEREBY GIVE CONSENT FOR THE SYJCC NURSERY/CAMP ADMINISTRATION TO BRING MY CHILD TO THE HOSPITAL.

IN CASE OF A LIFE-THREATENING EMERGENCY, I GIVE THE ABOVE DESIGNATED PHYSICIAN OR HOSPITAL PERMISSION TO TREAT MY CHILD APPROPRIATELY.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **NOTARY**

_____ _____

DATE **DATE**