Child's Personal Data Sheet

1. Name:_____DOB:_____
   Mother's Name:_____ Father's Name:_____
   Home Address:_____
   City:_____ State:_____ ZIP:_____ Phone:_____
   Mother's Employer:_____ Work Phone:_____ Work Hours:_____
   Father's Employer:_____ Work Phone:_____ Work Hours:_____
   Date enrolled in center:_____ Date withdrawn from center:_____
   Name of center:_____ Clock hours in care:_____

2. ***Emergency Contact Information***
   Mother Cell:_____ Father Cell:_____
   Name of person to call if parents cannot be reached:_____
   Relationship:_____ Phone:_____
   Address:_____City:_____State:_____ZIP:_____
   Is this person authorized to take child from the center? Yes/No
   List all other adults who are authorized to take the child from the center:

_____	_____
Name Relationship	Name Relationship
_____	_____
Address	Address
_____	_____
City State ZIP	City State ZIP
_____	_____
Phone Number	Phone Number

3. ***Medical Information***
   Child's Physician or emergency treatment facility:_____
   Address:_____City:_____State:_____Phone:_____
   I,_____Parent/Guardian of _____
   (Child's Name)
   do hereby give my consent to the Director of the Child Care Facility, or his duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents/guardians cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment, if the parents/guardians cannot be reached.

   Signature:_____Date:_____Witness:_____Date:_____

I hereby give____/do not give___the Director of the Child Care Facility or his appointed representative permission to give________________________________acetaminophen. I understand I will be notified
(Child's Name)
that the medication has been administered.

Signature:____Date:____________________

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4. ***Immunizations: Please provide a copy of your Child's Immunization Record.***
Verified by Health Department Record:_________ Physicians Record:____________ Other:_________

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5. ***Disease History: List the dates of each:***
Measles:_____________Mumps:_____________ German Measles:___________
Chicken Pox:________Whooping Cough:_________Contracted Tuberculosis: Yes_______/No_______
Frequent Ear Infections: Yes_______/No_______ Frequent Throat Infections: Yes_______/No______
Defective Heart: Yes______/No_______ Other Conditions or Comments:________________________

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6. ***Child's Developmental Needs:***
Physician or emotional problems the child might have:____
Child's special food needs*:* Formula:______________Diabetic diet:__________Allergies:__________
Special problems: Medications:____
Allergies:_________________________________Temper Tantrums:_____Diabetes:_____Frequent colds:_______Biting:_________Sun sensitivity:__________Seizures:_______Fainting spells:______Bedwetting:______Other____
Requires help in: Dressing:______Undressing:_____Toileting:_____Eating:____Washing hands:_____
Is child toilet trained? Yes_____/No_____ Words used in toileting:______________________
Favorite: Games:_____________________Toys:______________________Foods:_______________
Siblings? Yes_____/No_____ **Name(s) of siblings:**______________________________________
Type of childcare used before:____
Other useful information:____

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7. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

____ _____________________________
(Signature) (Date)

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Additional comments:____
____
____

PLEASE UPDATE THIS FORM A.S.A.P. IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

Student Checkout & Emergency Contact Form

In an attempt to protect your child while at school, the preschool will require **photo identification** on all persons checking out students. Unless this form is completed and on file with the classroom teacher, **children will be checked out only by the biological parent** as listed on the students birth certificate or to the **child's legal guardian.** If you wish to allow another person to check your child out of school, please complete this form below and return it to school as soon as possible. In case of parental separation or divorce, we will allow a child to be checked out by either biological parent unless there is a copy of a legal document on file at school prohibiting that person from checking out the student. Please ***print*** all information below.

Students Name:_____ Date:_____

Please allow the following persons listed below to check the above named child out of school:
(PLEASE LIST BIOLOGICAL and/or CUSTODIAL PARENTS ON LINES 1 & 2)

	Name	Relation to Student	Work/Cell Phone#	Home Phone#
1.				
2.				
3.				
4.				
5.				

The following persons may **NOT** check my child out of school:

	Name	Relation to Student
1.		
2.		
3.		

Custody papers are on file with the school? YES NO

PERSONS TO NOTIFY IN CASE OF AN EMERGENCY IF DIFFERENT THAN ABOVE:

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

_____ _____

Signature of person completing this form Relation to child

PLEASE UPDATE THIS FORM A.S.A.P. IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

ABSENT PARENT PERMIT FOR EMERGENCY MEDICAL/SURGICAL CARE

In the event that my child (listed below) may require medical and/or surgical care when I am unable to be reached, I hereby authorize evaluation, treatment and anesthetics, as deemed necessary by the _____ Hospital, and attending physician for the following child:

Child's Name:_____ DOB:_____ Age:_____

Allergies:_____

Present Medication:_____

Medical History:_____

Surgical History:_____

Other Pertinent Information:_____

Family Physician:_____Phone Number:_____

Family Medical Insurance Co:_____Policy #:_____

Person(s) able to provide authorizing signature when parent(s) are unable to be reached:

Name:_____ DOB:_____

Address:_____

Home Phone #:_____ Work Phone #_____

Relationship to the child:_____

This form is provided for parent's convenience in their absence. Authorization is valid beginning_____ and ending _____.

Authorizations must be renewed after one year from the date documented below:

Date of Permission Signature: _____.

Parents Signature: _____.

Address: _____

Home Phone #:_____ Work Phone #:_____

Mom's Cell #:_____ Dad's Cell #:_____

AUTHORIZATION IS TO BE LEFT WITH THE RESPONSIBLE ADULT AND PRESENTED TO THE HOSPITAL STAFF AT THE TIME EMERGENCY MEDICAL AND/OR SURGICAL CARE IS REQUIRED.

PLEASE UPDATE THIS FORM A.S.A.P. IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

Bloom Pediatric Academy

Getting to Know You and Your Family

What language are you most comfortable speaking?

What are your cultural beliefs concerning gender roles, parenting roles and education?

What holidays do your family acknowledge and/or celebrate?

What are your beliefs concerning children and play?

What are your expectations concerning the care of your child?

Thank you for your involvement in the life of your child. The staff at Bloom Pediatric Academy want your child to feel welcome, comfortable and safe. We also want to partner with the families of our students so we can better serve them by tailoring our curriculum to their needs.