

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 Date enrolled in center: _____ Date withdrawn from center: _____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
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: _____



4. Immunizations: Please provide a copy of your Child's Immunization Record.

Verified by Health Department Record: _____ Physicians Record: _____ Other: _____



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: _____



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: _____



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

(Signature) (Date)



Additional comments: _____

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.