Child's Personal Data Sheet

1. Name______________________________ DOB__________

Father's Name__________________ Mother's Name__________________

Home Address______________________________________

City__________________ State________ ZIP ________ Phone______

Father's Employer________________ Work Phone____________ Work Hours______

Mother'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Date enrolled in center________________ Date withdrawn from Center________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* father cell __________ mother cell __________

Name of person to call if parents cannot be reached______________________

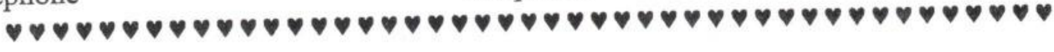
Relationship____________________ Telephone______________

Address______________ City______________ State________ ZIP______

Is this person authorized to take the child from the center?______________

List all other adults who are authorized to take the child from the center:

Name	Relationship	Name	Relationship	Name	Relationship
Address		Address		Address	
City / State / ZIP		City / State / ZIP		City / State / ZIP	
Telephone		Telephone		Telephone	



3. *Medical Information*

Child's Physician or emergency treatment facility______________________

Address______________ City______________ State________ Phone__________

I, ______________________ Father / Mother / Guardian **(CROSS OUT WORDS THAT DO NOT APPLY)** 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 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 cannot be reached.

Signed______________________ Date ________ Witness______________________ Date______

I hereby give ____ / do not give ____ the Director of the Child Care Facility or his appointed representative

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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_______ Physician's Record________ Other_____________

5. ***Disease History*: List the dates of each:**

Measles ________ Mumps_______German Measles_______ Chicken Pox ___________ Whooping Cough _______

___Contracted Tuberculous: Yes_____/No______ Frequent Ear Infections Yes______/ No_

______

Frequent Throat infection Yes_____/No______ Defective Heart Yes_____/No______

Other Conditions or Comments____________________________________

_____

6. ***Child's developmental needs:***

Physical 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___________ Bed wetting____________ 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 child care 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 student's 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 the 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.

Student's 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/Pager #	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 absense. Authorization is valid beginning ________________________ and ending __________________________.

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

Date of Permission Signature: _________________________.

Parent's 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.

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 discipline?

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.