**2024 - 2025**

**COMPLETE ONE FORM FOR EACH CHILD**

Please list children’s food allergies, if any:

Child’s Name Age Birthdate Grade Sex

CARE DESIRED: Before Care After Care Before & After Care

Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address

Father’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address

**Emergency Information:**

In the event that my child may require emergency medical, dental, or surgical care while I am unable to be reached, I hereby give my consent to medical, dental, or surgical treatment to:

Doctor/Clinic Name Address Phone

Hospital (circle one) – Broadlawns Mercy West Mercy (Downtown) Mercy West Lakes (60th) Lutheran Methodist (Downtown) Methodist West (60th) Blank Children’s Hospital

Dentist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to pay all the costs and fees contingent on emergency care or treatment for my child as secured or authorized under this consent.

**In an emergency please call:** (in case parents are unreachable)

Name/Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pick Up Permission- Please circle yes or no for the following:**

**Yes / No** I hereby give permission for my child to leave the center for fieldtrips in a vehicle provided by the center, or on foot. I give permission for my child to be transported to and from school in the vehicle provided by the center. A childcare employee will transport my child to and from school in a center provided vehicle.

**Yes / No** I hereby give permission for my child to leave the center with the following persons named below. It is the responsibility of the parent to notify the center, in writing, of any changes.

Name Relationship

Name Relationship

**Yes / No** I grant center staff the right to take photographs of my child engaged in center activities to be displayed within the center.

Names of persons who may not pick up the child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Separation, divorce, or other custody situations the center should be aware of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

**2024 - 2025**

**School Age Assessment & Health Form & Immunization Declaration**

1. **HEALTH ASSESSMENT - To be completed by parent.**

Child’s Full Name Birth Date

1. Significant illnesses and surgeries child has had (give age at time):

1. Any special health-related needs of child (allergies, medications, injuries, etc.):

1. **PHYSICAL ASSESSMENT**
2. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action?

1. Is the child subject to any conditions which limit classroom activities or physical education?

1. Is the child subject to any condition which may result in an emergency situation?

1. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observations?

1. Other information you would like to share:

FOR CENTERS SERVING SCHOOL-AGE CHILDREN OPERATING IN THE SAME SCHOOL

FACILITY IN WHICH THE CHILD ATTENDS SCHOOL:

**My signature below certifies that immunization information concerning my child has been provided and is available in the school file.**

Parent’s Signature Date