

PERSONS AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY (ONE REQUIRED)

LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of an accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize **Harris-Stowe State University's William L. Clay Sr. Early Childhood Development/Parenting Education Center** (DVN# 002144478) to contact the following:

PHYSICIAN OR CLINIC		TELEPHONE NUMBER ()	
ADDRESS	CITY	STATE	ZIP CODE
PREFERRED HOSPITAL		TELEPHONE NUMBER ()	
ADDRESS	CITY	STATE	ZIP CODE
CHILD'S DOCTOR'S FIRST NAME		CHILD'S DOCTOR'S LAST NAME	
TELEPHONE NUMBER ()			
ADDRESS	CITY	STATE	ZIP CODE
CHILD'S DENTIST'S FIRST NAME		CHILD'S DENTIST'S LAST NAME	
TELEPHONE NUMBER ()			
ADDRESS	CITY	STATE	ZIP CODE

FAMILY INFORMATION

Please list the names, ages and genders of the other children in the family.

LAST NAME	FIRST NAME
AGE	GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
LAST NAME	FIRST NAME
AGE	GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
LAST NAME	FIRST NAME
AGE	GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE

FAMILY INFORMATION (CONTINUED)

Please list the names, ages and genders of the other children in the family.

LAST NAME	FIRST NAME
AGE	GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
LAST NAME	FIRST NAME
AGE	GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
LAST NAME	FIRST NAME
RELATIONSHIP TO CHILD	GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
ANNUAL INCOME (BELOW \$65,860 FOR FOOD SERVICE INFORMATION ONLY) \$	

COMMENTS ON CHILD'S DEVELOPMENT

Please provide any additional information about the child that may be helpful to his or her teacher.

PLAY HABITS
EATING HABITS
SLEEPING PATTERN
FEARS
LIKES/DISLIKES
SPECIAL LANGUAGE
OTHER
PREVIOUS EXPERIENCE IN CHILD CARE <input type="checkbox"/> YES <input type="checkbox"/> NO

List any chronic or medical challenges that your child has, e.g., seizures, asthma, diabetes, heart disease, respiratory illness, drug reaction, etc.

Describe any allergies, including any foods that have caused adverse reactions or any food not given to the child for health or religious reasons (use separate sheet if necessary).

Has your child come in contact with tuberculosis?

<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHEN?
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