CREATIVE KIDS DAY CARE & PRESCHOOL
EMERGENCY & IDENTIFICATION FORM

CHILD'S FULL NAME:	**SEX: M F**	**BIRTHDATE:**
ADDRESS:		
FATHER'S NAME:	**DL#**	**SS#**
FATHER'S ADDRESS:		
MOTHER'S NAME:	**DL#**	**SS#**
MOTHER'S ADDRESS:		
PERSON RESPONSIBLE FOR CHILD:		

TELEPHONE NUMBERS

DAD'S HOME: ( )	**DAD'S WORK: ( )**	**DAD'S CELL: ( )**
MOM'S HOME: ( )	**MOM'S WORK: ( )**	**MOM'S CELL: ( )**

NAME OF PERSONS AUTHORIZED TO TAKE YOUR CHILD FROM THE FACILITY:

NAME	RELATIONSHIP	TELEPHONE NUMBER
		( )
		( )
		( )
		( )
		( )

CONSENT FOR MEDICAL TREATMENT

IT IS UNDERSTOOD THAT **EVERY** EFFORT SHALL BE MADE TO CONTACT THE UNDERSIGNED PARENT/GUARDIAN IN THE EVENT OF AN EMERGENCY. AS THE PARENT, LEGAL GUARDIAN, OR AGENCY REPRESENTATIVE, I HEREBY GIVE CONSENT TO CREATIVE KIDS DAYCARE & PRESCHOOL TO PROVIDE **ANY/ALL** EMERGENCY, DENTAL, OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OR DENTIST (D.D.S.). THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL-BEING OF MY DEPENDENT CHILD. I FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR **ALL** MEDICAL COSTS IF TREATMENT IS NEEDED.

_____ _____

(SIGNATURE OF PARENT/GUARDIAN) (DATE)

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	TELEPHONE NUMBER
PHYSICAN	**ADDRESS**	**TELEPHONE NUMBER**

If Physician cannot be reached what action should be taken? Call Emergency Hospital _____

Other (Explain): _____

ANY KNOWN ALLERGIES

FOOD: _____

MEDICATION: _____

SPECIAL TREATMENT PLAN: _____

ANY OTHER HEALTH CONCERNS WE SHOULD BE AWARE OF

_____

_____

_____

_____

ANY SPECIFIC FEARS YOUR CHILD MAY HAVE

_____

_____

_____

PLEASE SHARE WITH US SPECIAL FAMILY DYNAMICS

(single-parent family, step-parent/siblings, whom child lives with, custody arrangements, etc.)

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