IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	GENDER	TELEPHONE ( )
ADDRESS NUMBER	STREET	CITY	STATE ZIP	BIRTHDATE
PARENT/AUTHORIZED REPRESENTATIVE NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
PARENT/AUTHORIZED REPRESENTATIVE NAME	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY & AUTHORIZED TO TAKE CHILD FROM FACILITY

CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	EMAIL ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN? CHECK BOX BELOW

☐ CALL EMERGENCY HOSPITAL ☐ OTHER – EXPLAIN _____

TIME CHILD WILL BE PICKED UP Contracted time may vary	
SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	**DATE**

TO BE COMPLETED BY FACILTY DIRECTOR/ADMINISTRATOR/DESIGNEE

FORM REVIEWED BY SIGNATURE	**DATA ENTERED INTO CARECONNECT**
DATE OF ADMISSION	**LAST DATE OF ENROLLMENT**

Los Rios Community College District

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Child's History

Name of Child _____Birth Date _____ Gender _____

Parent/Guardian Name _____ Living in home with Child? _____

Parent/Guardian Name _____ Living in home with Child? _____

Languages spoken in the home _____

Developmental/Health History

Birth Weight _____ Condition at Birth _____

Walked at _____months Began talking at _____months Toilet Trained at _____months

Has child been under regular care of a physician? _____ Date of last Exam _____

Please list any past serious illnesses your child has had with approximate dates and specify if hospitalization was required _____

_____

Has your child been diagnosed with any special needs or disabilities? If yes, please describe_____

_____

Does your child have frequent colds, allergies, asthma, stomach aches, and/or nosebleeds? _____

If yes, please describe_____

Does child take medications on a regular basis? If yes, please describe _____

_____

Daily Routines

What time does your child wake up? _____ Go to bed? _____ Does child nap during the day? _____

If yes, at what time and for how long? _____

At what times does your child usually eat? _____

What is your child's typical mealtime routine?_____

Do you have any concerns about your child's eating habits? _____

How does your child let you know when he/she needs to use the bathroom? _____

Do you have any toileting concerns? _____

Additional Information

Has your child previously attended a program for young children? If yes, for how many hours/days per week?

_____

What makes your child upset and/or afraid? _____

Who does the disciplining? _____What form of discipline do you use? _____

Do you have any behavior concerns? _____

What are your child's favorite things? _____

Please share any additional information that would assist us in meeting your child's needs_____

_____

Parent Signature_____ **Date**_____

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ALLERGY STATEMENT

Child's Name: _____

If your child does NOT have allergies or a special diet, initial here. _____

This child is allergic to the following animals:

_____

_____

This child is allergic to the following foods:
If the child has a food allergy you must have the Medical Statement to Request Special Meals and/or Accommodations form (CNP-925) signed by the child's physician.

_____

_____

This child has the following special diet due to religious beliefs or personal choice:

_____

_____

Acceptable substitute foods are:

_____

_____

I give permission for my child's allergy and/or food preference information to be posted in the kitchens and classrooms of the Child Development Center.

Parent Name: _____

Parent Signature: _____