

Child's Personal Information Sheet: ID#:

DATE SUBMITTED: / /

(Office use only)

**FAMILY & SOCIAL HISTORY**

<b>Child's Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>
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<b>Billing Address:</b>	<b>Program:</b>
	<b>Class:</b>
	<b>Billing e-mail:</b>
<b>School Year:</b>	

**Parent or Guardian Information - ID#: [Family ID]**

<b>Name Father:</b>	<b>SS#:</b>
<b>Address</b>	<b>Home Ph#:</b>
	<b>Cell Ph#:</b>
<b>Employer</b>	<b>Work Hours</b>
<b>Work Phone</b>	
	<b>Ph#:</b>
	<b>Ext:</b>

<b>Name Mother:</b>	<b>SS#:</b>
<b>Address:</b>	<b>Home Ph#:</b>
	<b>Cell Ph#:</b>
<b>Employer</b>	<b>Work Hours</b>
<b>Work Phone</b>	
	<b>Ph#:</b>
	<b>Ext:</b>

**Other Family Information**

Other members of the household (include age/relationship):

<b>Parents Marital Status</b>	<b>Custody</b>	<b>Remarks::</b>
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Single Parent	<input type="checkbox"/> Both <input type="checkbox"/> Mother	
<input type="checkbox"/> Step Mother/Father <input type="checkbox"/> Divorced	<input type="checkbox"/> Father <input type="checkbox"/> Guardian	

**Please Note: Under this agreement either parent may pick up a child unless we have a copy of a court order restricting custody and/or visitation arrangements.**

**CHILDS'S ALTERNATE PICK-UP AUTHORIZATION:**

**Everyone authorized to pick up children at the Center including parents should always be prepared to present photo identification if requested by the staff person at the desk prior to release.**

**Check Box if - NO ONE IS AUTHORIZED AS ALTERNATE PICK-UP**

<b>Contact #1</b>		<b>Contact #2</b>		<b>Contact #3</b>		<b>Contact #4</b>	
<input type="checkbox"/> Authorized Pick-up Name:		<input type="checkbox"/> Authorized Pick-up Name:		<input type="checkbox"/> Authorized Pick-up Name:		<input type="checkbox"/> Authorized Pick-up Name:	
Relationship:		Relationship:		Relationship:		Relationship:	
Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell

**An Authorization Code Word can be used when you are forced to send someone who you have not previously authorized for pick-up, this word is used to identify the individual instead of their personal ID because we are not expecting them and will not have their name or your authorization prior to that time. Code Word: \_\_\_\_\_ (no more than 15 characters)**

**I authorize the above individuals to pick-up my child at anytime, I will make every effort to notify Recess Resources staff of who to expect, however it is not required and my child will be released to those I have authorized. Further if there is a change in authorization it is my responsibility to update this information with Recess Resources.**

<b>Parent/Guardian Signature:</b>	<b>Date:</b>
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**RECESS RESOURCES, INC. – Cub Care Juniors Pre-School**

Rev 1/10

1/22/10

Child Health History/Emergency Child Care ID#: \_\_\_\_\_ DATE SUBMITTED: / / (Office use only)

<b>Child's Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>
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Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and/or those who require health and related services of a type beyond that required by children generally. If your child does have special health care needs it is important for the wellbeing and safety of your child to disclose and discuss their needs with your child-care provider. Thank you

**Does your child require**  glasses/contact lenses,  hearing aide,  corrective shoes,  prosthesis,  other special device,  support services during school, **if yes to any item please describe.**

**Does your child take any medication regularly?**  NO  YES If yes indicate type of medication, dosage, time administered, and purpose:

**Check Box** I understand Recess Resources, Inc. staff members WILL NOT administer any over-the-counter or prescription medications to my child under any circumstances. If medication be required during child care I will make arrangements to administer the medications myself or have them administered by a family member. Further I will inform Recess Resources when to expect someone and their contact information. (Note: this includes emergency treatments such as epi pens and inhalers)

Other special health related information we should be made aware of:

Allergies	Special Instructions/Health Information

**EMERGENCY MEDICAL CONTACT AUTHORIZATIONS**

Child's Physician	Child's Dentist:	Other Medical Specialists
<b>Name:</b>	<b>Name:</b>	<b>Name:</b>
<b>Ph#:</b>	<b>Ph#:</b>	<b>Ph#:</b>
Emergency Hospital Preference	Insurance Carrier	Policy #

**Check Box** I am aware that a complete parent handbook stating policies and procedures is available on the centers website [www.cubcare.org](http://www.cubcare.org) and that copies of NYS OCFS Child Care Regulations and the Centers Health Care plan are available at every location. I can request a paper copy or e-mailed copy, or simply and opportunity to review documents at anytime.

**I have reviewed this form and all information is accurate to the best of my knowledge, I also understand that it is my responsibility to keep the center informed of changes in my child's health status, medications, health care providers, allergies, etc... to support the best care for my child.**

PARENT/GUARDIAN SIGNATURE	DATE
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**RECESS RESOURCES, INC. – Cub Care Juniors Pre-School**

1/22/2010

**Child’s Special Permissions Sheet** Family ID#:

Child ID#:

Child’s Name:	Birth Date	Age	Gender
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**GENERAL PERMISSION TO PARTICIPATE IN PROGRAM ACTIVITIES**

(Check box) **I hereby grant permission** for my child to use all of the play equipment and participate in all of the activities of the program premises under the supervision of staff members for neighborhood walking field trips or for field trips in an authorized vehicle.

**AUTHORIZATION TO RECEIVE MEDICAL CARE AND RELEASE FORM**

(Check box) **I hereby grant permission** for the Director or a staff person in charge to take whatever steps may be necessary to obtain emergency medical care. These steps may include, but are not limited to, the following:

- 1) Attempt to contact parent/guardian, the child's physician, or the persons listed on the emergency information sheet.
- 2) If we cannot locate you or your child's physician, we will do one or both of the following:
  - a) Call another physician or paramedic
  - b) Have the child transported by ambulance to an emergency hospital in the company of a staff member.
- 3) Any expenses incurred under item 2, above will be borne by the child's family.
- 4) The program will not be responsible for events that result from false information given at the time of enrollment or failure of parent or guardian to inform the center of changes in status with regard to health conditions, medications, insurance, primary care Doctor/Specialists or alternate authorization.

The undersigned, who are Parents or Guardians having legal custody of the above named minor, hereby authorize Recess Resources, Inc. (Cub Care Programs), into whose care the above named minor has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to said minor under the general or special supervision and upon the advise of a Physician or Surgeon licensed under the Medical Practice Act or by a Dentist licensed under the provisions of the Dental Practice Act.

The undersigned further authorizes Recess Resources, Inc. (Cub Care Programs) to have the above named minor released into the custody of its representative, should hospital care no longer be required.

This form is used only in extreme emergency, when said parents or guardians cannot be contacted.

**The above named minor is allergic to the following medications :**

**The above named minor regularly takes these medications:** (indicate name, dosage, frequency, reason):

**PARENT CONSENT FORM FOR BASIC FIRST AID SERVICES**

(Check Box) **I give my permission** for those members of the staff of Recess Resources, Inc. who have been trained in First Aid and/or CPR to administer Basic First Aid assistance to my child as necessary for injuries/illnesses that have occurred during or prior to their attending the program. First Aid administered may include the application of common over-the-counter topical ointments, such as bug spray, antibiotic ointments, lotions, creams, sunscreen, antiseptic wipes, etc.

**I further understand** that I will be informed of any injuries/illnesses and treatment given through an Incident Report available when picking up my child. I will also be contact via phone if the situation is considered serious.

**Please indicate if your child has any allergies, sensitivities or care restrictions** that we need to be aware of in treating your child for injuries. (example: allergic to latex, do not use anything but cloth bandages)

Signature	Date
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