Date of Enrollment: _____ Date of Discharge: _____

Child's Personal Data Sheet

1. Child's Name: _____ DOB____/____/____

Primary Caregiver:_____ Relationship to Child:_____

Email Address:_____

Home Address:_____ City:_____State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Place of Employment:_____ Work Hours: from_____to_____

Secondary Caregiver:_____ Relationship to Child: _____

Email Address:_____

Home Address:_____ City:_____State:____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Place of Employment:_____ Work Hours: from_____to_____

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2. Emergency Contact Information:

Name of person to call if parents cannot be reached:_____

Home Address:_____ City:_____State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Is this person authorized to take the child from the center? Yes_____ No_____

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3. List all other adults who are authorized to take the child from the center:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

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4. Medical Information

_____ _____
Child's Physician OR Emergency Treatment Facility Phone Number

Address:_____ City:_____State:_____ Zip:_____

I, _____, mother/father/guardian ***(Circle One)***
of _____, do hereby give my consent to the director of the Child Care Facility, or his duty representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duty licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or his duty appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

_____ _____
Signature of Parent or Guardian ***Date***

_____ _____
Witness ***Date***

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5. Consents:
I hereby give_____/do not give_____ the Director of the Child Care Facility or his appointed representative permission to give _____ Acetaminophen.
(Child's Name)

I understand I will be notified that the medication has been administered.

Signature:_____ Date:_____

I hereby give_____/do not give_____ written permission for the use of suntan lotions/ sunscreen for my child in permit able weather. School age children may apply sunscreen to themselves with supervision. In accordance with Minimum Licensing Requirements:

Signature:_____ Date:_____

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6. Acknowledgments:

This is a statement of verification that I have been informed that childcare licensing/ child maltreatment investigation and/or law enforcement may possibly interview my child for the purpose of determining licensing compliance or for investigative purposes.

Signature:_____ Date:_____

This is to acknowledge that I have received a copy of or given the website address to the electronic version of a list of Kindergarten Readiness Skills for my child (3 and 4YO).
Calendar: http://humanservices.arkansas.gov/dccece/classroom_docs/DHS_RICalendar.pdf
Checklist: http://arbetterbeginnings.com/parents-families/resource-library/kindergarten-readiness-checklist

Signature:_____ Date:_____

This is a statement of verification that I have been informed of the behavior guidance policy practiced.

Signature:_____ Date:_____

This is a statement of verification that I have received information regarding Shaken Baby Syndrome in accordance with Carter's Law (all parents of infants).

Signature:_____ Date:_____

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7. Pertinent Medical and Developmental Information:

Immunizations: I have provided a copy of my child's Immunization Record:
Yes_____ No_____

Disease History: Measles_____ Mumps _____ German Measles _____
Chicken Pox_____ Whooping Cough_____

Frequent colds: Yes____No____
Defective Heart: Yes____No____
Sun Sensitivity: Yes____No____
Fainting Spells: Yes____No____

Biting: Yes____No____
Seizures: Yes____No____
Diabetes: Yes____No____
Temper Tantrums: Yes____No____

Contracted Tuberculosis: Yes____No____
Frequent Ear Infections: Yes____No____
Frequent Throat Infections: Yes____No____

Allergies:_____ Medications:_____

Physical or Emotional concerns child might have_____

Other conditions or comments:_____

Special Food Needs: Formula_____ Diabetic Diet_____
Other_____
Is Child Toilet-Trained: Yes____No____ Words used in Toileting_____

Siblings? Yes____No____ Name(s) of siblings:_____

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8. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signature:_____ Date:_____

9. I have received a copy of the handbook and agree to the policies therein.

Signature:_____ Date:_____