Child's and family Personal data Sheet

Name____DOB_________________________

Father's Name_______________________________Home phone________________

Father's Work____

Work number__________________________ Cell_________________________

Mother's Name_____________________________Home phone_________________

Mother's Work____

Work number_________________________Cell_________________________

Emergency Contact Information

Name________________________________Relation___________________________

Phone number__________________/______________________________

Address____________________________________City_________________________

Is this person Authorized to take the child from the center? ___________________

Name________________________________Relation___________________________

Phone number__________________/______________________________

Address____________________________________City_________________________

Is this person Authorized to take the child from the center? __________________

Name______________________________Relation_________________________
Phone number_________________/____________________________

Address_________________________________City_______________________

Is this person Authorized to take the child from the center? __________________

Medical Information

Child's Doctor___________________________Hospital_____________________

Doctor phone_____________________Hospital phone____________________

I ___________________________do hereby give my consent to In His Care Children's center to authorize medical or surgical aid as deemed necessary and expedient by a duly licensed physician, recognized physician, or surgeon for ____________________________Childs name

When the parents cannot be reached. It is also authorized In His Care representatives may transport child for emergency medical treatment if the parents cannot be reached.

Parents Signature__________________________/________________________

Date__________________________

Over the counter Medication authorization

I hereby give In His Care Representatives permission to administer the following over the counter medication. It will be administered following the directions of the label from the manufacturer or Physician's written instructions. I will not hold In His Care Children's Center liable when the medication is administered properly.

Baby wipes Yes or No Brand___________________________________

Diaper Ointment Yes or No Brand___________________________________

Sunscreen Yes or No Brand___________________________________

Insect Repellent Yes or No Brand___________________________________

Band-Aids Yes or No Brand___________________________________

First aid ointments Yes or No Brand___________________________________

Acetaminophen Yes or No Brand___________________________________

Ibuprofen Yes or No Brand___________________________________

Benadryl Yes or No Brand___________________________________

First aide Spray Yes or No Brand__________________________________

Parents signature___________________________/__________________________

Date signed_________________________________

Disease History

List any diseases child has experienced, child currently has, or common health issues that child deals with,

_________________________/___________________________/_____________________

_______________________/___________________________/______________________

List any medications child is taking ____

____

____

List all allergies

Food____________________/_________________________/________________________

Environment ______________________/___________________________

______________________/____________________________

Child's Bio

Likes_______________________________________/______________________________

____/______________________________

Dislikes

___________________________________/_____________________________________

___________________________________/_____________________________________

Siblings Yes or No Names and ages _____________________________________

____

Formula or Breast feed   If formula what brand? ___________________________

Physical limitations____

Emotional needs____

Temperament____

Any other useful information____

____

____

I the parent/guardian of this child, understand that I may ask for a conference with the representatives of In His Care Center whenever it is needed,

Signature_______________________________Date________________________

Any information that you would like In His Care Center to know: