Ashland Child Development CHILD'S HEALTH AND EMERGENCY INFORMATION

Child's Name:______________________________ Birth Date: ____________________
Parent or Guardian Name (s):______________________________ Home Telephone: ____________________
Home Address: ______________________________ Cell Phone: ____________________
Mother's/Guardian's Place of Work: ______________________________ Telephone #: ____________________
Father's/Guardian's Place of Work:____________________ Telephone #: ____________________

Only the following people can pick up my child:

____

Name Telephone # Relationship to child

____

Name Telephone # Relationship to child

GENERAL STATUS OF CHILD'S HEALTH: ____
____

Allergies or restrictions on child's participation in activities: ______________________________
____

Specific instructions from parent or physician: ______________________________________

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GENERAL STATUS OF CHILD'S HEALTH: ____
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Allergies or restrictions on child's participation in activities: ______________________________
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Specific instructions from parent or physician: ______________________________________

IN EMERGENCY, when parent cannot be reached, notify:

Name: ______________________________ Relationship to child: ______________
Address:______________________________ Phone #: ____________ Cell #: __________
Name of Physician: ______________________________ Phone #: ______________
Name of Hospital: ______________________________ Phone #: ______________

PERMISSIONS: In case of accident or illness requiring medical attention in the parent/guardian's absence, I authorize:

Ashland Child Development Center to seek emergency medical care for______________________________
Child's Name

I give permission for **Ashland Child Development Center** to transport ______________________________
Child's Name

I have received a copy of the child and parent rights as required by KRS 199.898. (Section 14 (4) and have received the name, address, and telephone number of the Cabinet for registering a complaint if I believe the family child care home provider is not meeting family child care standards. (Section 14 (3).

______________________________ ______________________________
Signature of Parent or Guardian Date

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IN EMERGENCY, when parent cannot be reached, notify:

Name: ______________________________ Relationship to child: ______________
Address:______________________________ Phone #: ____________ Cell #: __________
Name of Physician: ______________________________ Phone #: ______________
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Signature of Parent or Guardian Date