

SAMPLE CHILD CARE- CHILD INFORMATION FORM for EMERGENCY/DISASTER PREPAREDNESS

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this form. Sign and date where indicated.
- (2) If your child has a medical condition, which might require emergency medical care, complete the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY. DATE: _____

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency/disaster:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

Child's Primary Physician or Source of Health Care _____ Telephone _____

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ **Date** _____

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

SAMPLE CHILD CARE CHILD INFORMATION FORM -continued

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____

Name _____ Address _____

Mother's Home (If different from above) _____

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

Work Telephone _____ Cellular Phone _____ E-mail _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____

Name _____ Address _____

Father's Home (If different from above) _____

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

Work Telephone _____ Cellular Phone _____ E-mail _____

Name of Person Authorized to Pick Up Child (daily)

1. _____
Last First Relationship to Child

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

2. _____
Last First Relationship to Child

Address _____ Street/Apt. # _____ City _____ State _____ Zip Code _____

Name of person(s) with court ordered restricted access to the child

1. _____

2. _____

3. _____

ANNUAL UPDATES _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

SAMPLE CHILD CARE CHILD INFORMATION FORM -continued

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s), which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ **Date of Birth:** _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Management Data:

Allergies/Reactions: Medications/Foods to be avoided and why:

1.
2.
3.

Procedures to be avoided and why:

1.
2.
3.

Immunizations

	Dates	Dates	Dates	Dates	Dates		Dates	Dates	Dates	Dates	Dates
DPT						HEP B					
CPV						Varicella					
MMR						TB Status					
HIB						Other					

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for:

(2) If signs/symptoms appear, do this:

(3) To prevent incidents:

SAMPLE CHILD CARE CHILD INFORMATION FORM –continued

THE FOLLOWING ARE EMERGENCY MEDICAL INSTRUCTIONS FOR A CHILD WITH SPECIAL NEEDS

Current Specialty Physician:		Emergency Phone:	
		Fax:	
Current Specialty Physician:		Emergency Phone:	
		Fax:	

Diagnoses/Past Procedures/Physical Exam:

1.	Synopsis:
2.	Baseline physical findings:
3.	Baseline vital signs:
4.	Baseline neurological status:
Medications:	Significant baseline ancillary findings: (lab, x-ray, ECG)
1.	
2.	
3.	Special Equipment/Prostheses Appliances/Advanced Technology Devices:
4.	
5.	

Antibiotic prophylaxis:

Indications:

Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements:

Problem	Suggested Diagnostic Studies	Treatment Considerations

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

COMMENTS ON CHILD, FAMILY OR SPECIFIC MEDICAL ISSUES:

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____)_____
Telephone Number

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