**Child Information Card**

**State of Delaware**

**Department of Services for Children, Youth, and Their Families**

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| **Child’s Information** |
| Child’s name: | Date of birth: | Date of enrollment: | Date of discharge: |
|       |       |       |       |
| Child’s address: | Hours and days child is scheduled to attend: |
|       |       |
| **Parent/Guardian Information (1)**Emergency Contact/Authorized to Pick-up Child | **Parent/Guardian Information (2)**Emergency Contact/Authorized to Pick-up Child |
| Name:  | Name:  |
|       |       |
| Address, if different from child’s: | Address, if different from child’s: |
|       |       |
| Home phone: | Cell phone: | Home phone: | Cell phone: |
|       |       |       |       |
| Work phone: | Hours of employment: | Work phone: | Hours of employment: |
|       |       |       |       |
| Employer name and address: | Employer name and address: |
|       |       |
| **Additional Emergency Contacts and People Authorized to Pick-up Child**  |
| Name: | Address: | Phone: |
|       |       |       |
| Name: | Address: | Phone: |
|       |       |       |
| Name: | Address: | Phone: |
|       |       |       |
| [ ]  **Emergency Medical Care**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment. |
| [ ]  **Transportation**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of parent/guardian | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
|  |  |
| **Medical Information** |
| Name of child’s physician: | Office phone: |  |
|       |        |  |
| Special medical information, medications, allergies, diet: | Health insurance identification information: |
|       |       |
| *The above information is necessary for your child’s protection and this facility is required to have it. Keep this information current.* |