

FAMILY HOME DAY CARE APPLICATION
Child Information Sheet

Child's Legal Name: Last _____ First: _____

Social Security Number: _____ Race: Black White Hispanic Sex: _____

Date of Birth: _____ Entrance Date: _____ Withdrawal Date: _____

Family Information

Primary Adult: _____ Adult SSN: _____

Family Name: _____ Parental Status: One Two Foster Non-Parent

Number in Family: ____ Number in Household: ____ Num. Children: ____ By Age: 0-3 __ 4-5 __

Parent/Guardian (for mailing labels) _____ Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone () Home () Work: _____ Phone Other: _____

Employment: _____

Employment Address: _____ Phone Number: _____

Person to contact in case of emergency when parent(s) cannot be reached:

Name: _____ Address: _____ Phone #: _____

Name: _____ Address: _____ Phone #: _____

Name: _____ Address: _____ Phone #: _____

The child may be released to the person(s) signing this agreement or to the following:

Name: _____ Address: _____ Phone #: _____

Name: _____ Address: _____ Phone #: _____

Name: _____ Address: _____ Phone #: _____

Eligibility Information

AFDC: Yes__ No__ Medical Elig. Stat: __ Eligible __ Not Potentially Child Med./Insur. #: _____

Income Status: Eligible Over / Family Income _____ Disability Status: (Zero Disability) x (Suspected)

Income Verified: Yes () No () W-2 () Check Stub () Tax Return () Letter () Other ()

Optional: Child has disability or special need: No () Suspected Yes (If yes, give diagnosis, date and source)

Parent / Guardian's signature: _____ Date: _____

CHILD'S MEDICAL INFORMATION:

Child's Physician or Clinic's Name (Child's Primary Health Source)

Does your child have allergies or other physical problems, mental health disorder, mental retardation or developmental disabilities, which would limit the child's participation in the center's program and activities?

Yes No If yes, specify: _____

Does your child have allergies (insects, medications, food, etc.)? Yes No

If yes, specify: _____

Are there any special procedures required in caring for your child? Yes No

If yes, specify: _____

Parent or Guardian Signature

Date

Doctor's Name: _____ Phone #: _____

List person(s) authorized to sign your child out from childcare:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

HOSPITAL AGREEMENT

I hereby authorized the Family Child Care Home to render emergency care to my child,
_____ in the event that such is needed while the child is in attendance
at the Family Child Care Home.

I understand that I will be contacted prior to such care being rendered if at all possible, if
this is not possible, I have submitted the Family Home Care provider the names of three (3)
individuals who may act of my behalf.

Parent / Guardian's signature: _____ Date: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, _____, give the personnel at the Family Child Care Home
permission to authorize emergency medical care for my child _____

When I am not available.

Parent / Guardian's signature: _____ Date: _____

CHANGES IN FAMILY INFORMATION

I, _____, agree to notify the Family Child Care Home of any
Changes in the family phone numbers, address, work location, emergency numbers, family physicians
or etc.

Parent or Guardian Signature

Date

ACKNOWLEDGEMENT OF ESCORTING POLICIES

I, _____, understand that my child _____
must be escorted in and out of the Family Child Care Home. The Family Child Care Home will not
allow the child to leave without an escort.

Parent or Guardian Signature

Date