

## Child and Family Information

### Child's Information

Child's Full Name: \_\_\_\_\_  
Age of Child: \_\_\_\_\_ Birthdate of Child: \_\_\_\_\_  
Child's Nickname: \_\_\_\_\_

### Parent's/Family Information

Parent(s) Name(s): \_\_\_\_\_  
Parent's Location During Caregiving: \_\_\_\_\_  
Location Telephone Number: \_\_\_\_\_  
Cell Telephone Number: \_\_\_\_\_  
Work Telephone Number: \_\_\_\_\_

### Information about My Child

My child's favorite toys: \_\_\_\_\_  
Unique words/phrases my child uses: \_\_\_\_\_  
Foods my child likes or is permitted and mealtimes: \_\_\_\_\_  
\_\_\_\_\_  
Foods my child does not like or cannot eat: \_\_\_\_\_  
\_\_\_\_\_  
TV shows my child can watch: \_\_\_\_\_  
My child's favorite activities: \_\_\_\_\_  
\_\_\_\_\_  
Activities I do not wish my child to do: \_\_\_\_\_  
My child's sleep habits and nap/bedtimes: \_\_\_\_\_  
\_\_\_\_\_  
My child's fears are: \_\_\_\_\_  
Guidelines I use in letting my child use the computer or other similar devices: \_\_\_\_\_  
\_\_\_\_\_  
Other information that will help you provide loving, good care: \_\_\_\_\_  
\_\_\_\_\_

### Health Information about My Child

My child has allergies.: yes \_\_\_\_\_ no \_\_\_\_\_ If yes, please describe.

Allergy	Reaction
_____	_____
_____	_____

My child has asthma.: yes \_\_\_\_\_ no \_\_\_\_\_ If yes, please describe condition and medical treatment. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

My child has a health condition.: yes \_\_\_\_\_ no \_\_\_\_\_ If yes, please describe condition and how it is treated.

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My child takes medicine currently, either prescribed or over-the-counter.: yes \_\_\_ no \_\_\_  
If yes, please describe.

Name	Purpose	Dose/Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other relevant health information is.

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### Emergency Information

**If I cannot be reached, contact:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Location: \_\_\_\_\_  
Work Telephone Number: \_\_\_\_\_  
Cell Telephone Number: \_\_\_\_\_  
Other Telephone Number: \_\_\_\_\_

**A neighbor who can be contacted in an emergency:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Telephone Number: \_\_\_\_\_  
Cell Telephone Number: \_\_\_\_\_  
Other Telephone Number: \_\_\_\_\_

Our 911 address is \_\_\_\_\_  
Direction to our home: is \_\_\_\_\_

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**Medical/Professional Emergency Personnel**

The name of my child's <b>physician</b> :	_____	Telephone Number:	_____
The name of my child's <b>dentist</b> :	_____	Telephone Number:	_____
<b>Other health care provider</b> ,	_____ (field of practice)		
	_____	Telephone Number:	_____
Preferred <b>hospital</b>	_____	Telephone Number:	_____
Address of hospital	_____		
<b>Fire department</b>	_____	Telephone Number:	_____
Preferred <b>ambulance</b>	_____	Telephone Number:	_____

**Other important numbers**

Organization	Telephone Number
Poison Control	_____
_____	_____
_____	_____

**My child's health insurance information**

Provider:	
Insured's Name and ID#:	
Group ID#:	Policy ID#: