Please Provide All, Address + Phone numbers

STEPPING STONES CHILD DEVELOPMENT CENTER

Entrance Date_____ **Withdrawal Date**_____

Child's Name_____Sex___Age_____Date of birth_____

Home Address (Street)_____

City_____State_____Zip_____

Home Phone Number_____

Father's Name_____Home Phone Number_____

Father's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Father's Place of Employment _____Work Phone _____

Employer's Street Address_____City_____State_____Zip_____

Mother's Name_____Home Phone Number_____

Mother's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Mother's Place of Employment_____Work Phone #_____

Employer's Street Address_____City_____State_____Zip_____

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

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

*Name_____Address_____
(Street-City-State-Zip)

Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

*Name_____Address_____
(Street-City-State-Zip)

Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name_____Telephone Number_____

Name_____Telephone Number_____

Name_____Telephone Number_____

Name of Public or Private School child attends, if any:_____

Child's doctor or clinic name_____

Doctor/clinic phone #_____

My child has the following special needs_____

_____

_____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:_____

_____

_____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns:_____

_____

_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name)_____ Date of birth_____
suffer an injury or illness while in the care of (Facility name)_____
and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian:_____
Signature

Date:_____

Facility Administrator/Person-In-Charge_____
Signature

Date:_____

Please Fill out Entire Form

HEALTH AND EMERGENCY PERMISSION RECORD
and
VEHICLE EMERGENCY MEDICAL INFORMATION

CHILD'S NAME: _____ DOB: _____
ADDRESS: _____

CHILD'S PRIMARY CLINIC/DOCTOR: _____
DOCTOR'S PHONE NO.: _____

FATHER'S NAME: _____
FATHER'S HOME PHONE: _____ WORK/CELL: _____

MOTHER'S NAME: _____
MOTHER'S HOME PHONE: _____ WORK/CELL: _____

FIRST PARENT TO CONTACT IN CASE OF AN EMERGENCY:
FATHER/MOTHER (CIRCLE ONE)

PERSON TO NOTIFY IN AN EMERGENCY IF PARENTS CANNOT BE REACHED:

NAME: _____ RELATION: _____
CONTACT NUMBER: _____

DOES THE CHILD HAVE ANY PHYSICAL PROBLEMS, MENTAL HEALTH DISORDERS, MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES WHICH WOULD LIMIT THE CHILD'S PARTICIPATION IN THE CENTER'S PROGRAMS AND ACTIVITIES? YES: _____ NO: _____
IF YES, SPECIFY: _____

DOES YOUR CHILD HAVE ALLERGIES? (FOOD, MEDICATIONS, INSECTS, ETC.)
YES: _____ NO: _____
IF YES, SPECIFY: _____

ARE THERE ANY SPECIAL NEEDS, CONDITIONS OR PROCEDURES REQUIRED IN CARING FOR YOUR CHILD? YES: _____ NO: _____
IF YES, SPECIFY: _____

CHILD'S CURRENT PRESCRIPTION MEDICATIONS: _____

I GIVE MY PERMISSION FOR STEPPING STONES CHILD DEVELOPMENT CENTER TO SEEK MEDICAL ATTENTION FOR MY CHILD IN THE EVENT OF AN EMERGENCY IF I CANNOT BE REACHED AND TO HOLD HARMLESS AND RELEASE STEPPING STONES FROM ALL LIABILITY. I AGREE TO BE FULLY RESPONSIBLE FOR ALL MEDICAL EXPENSES INCURRED DURING THE TREATMENT OF MY CHILD. I AGREE TO KEEP STEPPING STONES INFORMED OF CHANGES IN TELEPHONE NUMBERS WHERE I CAN BE REACHED.

PARENT'S SIGNATURE: _____ DATE: _____

WITNESS: _____

EMERGENCY CONTACT PROCEDURE WILL BE:

1. CONTACT PARENT(S)
2. CONTACT PERSON LISTED IF PARENT(S) CANNOT BE REACHED
3. CALL EMERGENCY MEDICAL TEAM, IF NECESSARY
4. HAVE EMERGENCY MEDICAL TEAM TRANSPORT CHILD TO HOSPITAL
5. WILL SEEK MEDICAL ATTENTION FROM: GWINNETT MEDICAL CENTER, 3620 HOWELL FERRY ROAD, DULUTH, GA 30096, 678-312-6800