

BLOSSOM DAY CARE CENTERS, INC CHILD/PARENT INFORMATION RECORD

HEALTH INFORMATION

Health Status: "I certify _____ is in good health and free of any communicable illness."

Signature: _____ Date: _____

Child's physician or clinic name, address and phone number: _____

Child's dentist or clinic name, address and phone number: _____

Does your Child have any Individual Special needs? If yes, please specify: _____

Is your Child Allergic to any foods, medical, etc. If yes, please specify: _____

Name of health insurance: _____ Policy Number: _____

IF CHILD IS NOT COVERED BY A HEALTH PLAN PARENT/GUARDIAN MUST CHECK AND INITIAL ONE OF THE BELOW OPTION PRIOR TO CHILD'S ATTENDANCE:

I/WE DECLINE THE ACCIDENTAL INSURANCE COVERAGE FOR THIS CHILD.

I/WE DECLINE THE ACCIDENTAL INSURANCE COVERAGE OFFERED AND AGREE TO ASSUME ALL FINANCIAL RESPONSIBILITY FOR MY CHILDS MEDICAL NEEDS.

CHILDREN WILL NOT BE ADMITTED UNLESS AN IMMUNIZATION RECORD IS PRESENTED AND IMMUNIZATION ARE UP TO DATE. COPY OF IMMUNIZATION RECORD OR CERTIFICATE OF EXEMPTION MUST BE ATTACHED.

TRANSPORTATION

I AUTHORIZE BLOSSOM CHILD CARE CENTERS TO TRANSPORT MY CHILD _____ TO AND FROM _____ SCHOOLS, AND ON ALL FIELD TRIPS.

signature of mother/guardian date

signature of father/guardian date

IF A MEDICAL EMERGENCY OCCURS AND I/WE CANNOT BE REACHED , I/WE HEREBY AUTHORIZE THE PERSON IN CHARGE AT BLOSSOM DAY CARE CENTER, INC. TO TRANSPORT MY CHILD TO THE NEAREST AVAILABLE MEDICAL FACILITY AND/OR CALL MY PHYSICIAN.

signature of mother/guardian date

signature of father/guardian date