Child Information Sheet

| Name | | | | S. C. |
|--------------------|--------------------------------|-------------------------------------|----------------------------|---------------------------|
| Address | | | | |
| Address | | Height Weight | Hair Color | Eye Color |
| City | State Zip | Enrollment Date | Gender | Date of Birth |
| | State Zip | Lindiment Date | Gender | Date of Dirth |
| Parent/Guardian | | | | |
| Name | | | | |
| Address | | Employer | Employer Occupation | |
| Address | | Address | | |
| City | State Zip | City | | State Zip |
| Home Phone | Cell Phone | Work Phone | | |
| | | Non Thore | | |
| Parent/Guardian | | | | |
| Name | | | | |
| Address | | Employer | 0 | Occupation |
| Address | | Address | | |
| City | State Zip | City | | State Zip |
| Home Phone | Cell Phone | Work Phone | | |
| | | Authorized to rei | maya ahild | |
| mergency Conta | acı | Authorized to rei | nove child. | |
| Name | | Name | | Phone |
| Address | | Name | | Phone |
| Address | | Name | | Phone |
| City | State Zip | Name | | Phone |
| Phone | | Name | | Phone |
| | ancod physician is authorized | | omuchild | |
| ne ronowing lice | ensed physician is authorized | a to give emergency care t | o my child. | |
| | Primary Physician | Insurance Company | | Contract and Group Number |
| Address | | Phone | | |
| City | State Zip | If unavailable, another licensed of | doctor may treat my child: | 🗌 Yes 🗌 No |
| The following lies | ensed dentist is authorized to | aive emergency care to r | ny child | |
| ne ronowing lice | ensed dentist is duitonzed la | y give emergency care to h | ny chilu. | |
| | Primary Physician | Insurance Company | | Contract and Group Number |
| Address | | Phone | | |
| | | | | |