

Child Information Sheet



Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Height _____ Weight _____ Hair Color _____ Eye Color _____

Enrollment Date _____ Gender _____ Date of Birth _____

Parent/Guardian

Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Work Phone _____

Parent/Guardian

Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Work Phone _____

Emergency Contact

Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Phone _____

Authorized to remove child.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

The following licensed physician is authorized to give emergency care to my child.

Primary Physician

Address _____

City _____ State _____ Zip _____

Insurance Company

Contract and Group Number

Phone _____

If unavailable, another licensed doctor may treat my child: Yes No

The following licensed dentist is authorized to give emergency care to my child.

Primary Physician

Address _____

City _____ State _____ Zip _____

Insurance Company

Contract and Group Number

Phone _____

If unavailable, another licensed doctor may treat my child: Yes No

Signature _____

Date _____