STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE
					( )

ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE

FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE	BUSINESS TELEPHONE
				( )	( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

■ CALL EMERGENCY HOSPITAL ■ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

EMERGENCY PROVISIONS

In the event of a major earthquake, it is our plan to be as well prepared as possible to insure safety and comfort of our children. One aspect of that plan is to store an emergency food bag for every child. The preschool will provide the premade food bags.

We ask that you provide a note from you, reassuring your child that you will pick them up as soon as possible (a family photo would also be comforting), and any additional supplies and instructions for your child with special health needs (i.e. allergy to bee stings, diabetes or asthma).

Karen Wilson
Director

In case of a disaster, I give permission for emergency treatment for my child.

(Parent signature) _____

My child is in need of medication within a 24 hour period…… yes____ No____
My child has asthma…… yes____ No____

If yes to either, please include any medication.

My child is allergic to the following medication_____

My child's doctor is_____ Phone_____

My child's dentist is_____ Phone_____

Out of State emergency contact:

Name_____ Phone_____

Name_____ Phone_____