

CACFP Enrollment: Yes: ☐ No: ☐

BK ☐ LN ☐ SU ☐ AM Snk ☐ PM Snk ☐ Evng Snk ☐

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address			
Street/Apt. #	City	State	Zip Code

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

Name of Person Authorized to Pick up Child (daily)		
Last	First	Relationship to Child

Address _____

Street/Apt. #	City	State	Zip Code
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Any Changes/Additional Information_____

ANNUAL UPDATES

(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address			
Street/Apt. #	City	State	Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address			
Street/Apt. #	City	State	Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____

Street/Apt. #	City	State	Zip Code
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Child's Physician or Source of Health Care _____ Telephone _____

Address			
Street/Apt. #	City	State	Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____) _____
Telephone Number