

Enrollment Date: _____
Days of Care: _____ Hours of Care: _____



CARELOT CLUBHOUSE
@ _____
EMERGENCY INFORMATION



Child's Name: _____ Date of Birth: _____
Mother/Guardian: _____ Father/Guardian: _____
Address: _____ Address: _____
Home Phone: _____ Cell: _____ Home Phone: _____ Cell: _____
Employer: _____ Employer: _____
Employer Address: _____ Employer Address: _____
Employer Phone: _____ Employer Phone: _____
Email: _____ Email: _____

Child's Insurance Carrier: _____ Policy #: _____
Hospital Choice: _____
Child's Physician: _____ Physician Phone: _____
Physician Address: _____
Dentist: _____ Dentist Phone: _____
Dentist Address: _____

Known Allergies: _____
Known Medical Problems: _____
Last Tetanus Shot: _____

EMERGENCY CONTACTS IF PARENTS ARE NOT AVAILABLE: (PLEASE LIST TWO)

NAME: _____ Relationship to child: _____ Home Phone: _____ Work Phone: _____
NAME: _____ Relationship to child: _____ Home Phone: _____ Work Phone: _____

***** AUTHORIZATION FOR PICK UP *****

At least TWO (2) persons authorized to pick up your child other than parent/guardian & emergency contacts

Name: _____ Relationship to child: _____ Phone: _____
Name: _____ Relationship to child: _____ Phone: _____
Name: _____ Relationship to child: _____ Phone: _____
Name: _____ Relationship to child: _____ Phone: _____

List any persons NOT authorized to pick up your child:

Name: _____ Brief Description: _____
(A copy of the court order confirming unauthorized pick up should be on file)

I/We have completed all of the above information and agree to notify the center of any changes that may occur.

Parent/Guardian Signature

Date

Parent/Guardian Signature

OVER-MORE INFORMATION ON THE REVERSE

Emergency From-CH-6/15/2010



CARELOT CLUBHOUSE

AUTHORIZATION OF CONSENT OF MEDICAL TREATMENT FOR A MINOR CHILD

I (We) _____ do hereby state that I am (we are) the natural parent(s)/
Parent(s)/guardian(s) name(s)
(guardians) having legal custody of _____, a minor born on
child's name
_____ who resides with me (us) at _____
date of birth address

I/We give permission to Carelot Children's Center personnel to provide first aid for the child named above and to take the appropriate measures including contacting the emergency medical services (EMS) system and arranging for transportation to the hospital listed on the emergency form or the nearest medical facility. I/We understand that a copy of this emergency form will be sent with the emergency medical services (EMS). I/We also give permission to arrange for necessary medical treatment to be rendered to the minor under general supervision, and on the advice of any physician or surgeon licensed in the State of Connecticut when the need for such action is taken. I hereby absolve Carelot Children's Center, Inc. and its staff of any and all liability claims, courses of action, including attorney fees, and any and all medical expenses resulting from this action.

Parent/Guardian

Date

Parent/Guardian

**This form must have TWO signatures.
If the child is in the custody of only one parent or legal guardian, please indicate.**

AUTHORIZATION FOR ACTIVITIES OFF GROUNDS

I hereby consent to have my child participate in walks and/or field trips supervised by the Carelot staff to nearby points of interest off the center grounds. I understand that I will be notified and required to sign a separate form for field trips needing any type of transportation.

Parents/Guardians Signatures

Date

OVER---- MORE INFORMATION ON THE REVERSE