

## Child and Family Information

### Child's Information

Child's Full Name:

Age of Child:

Birthdate of Child:

Child's Nickname:

### Parent's/Family Information

Parent(s) Name(s):

Parent's Location During Caregiving:

Location Telephone Number:

Cell Telephone Number:

Work Telephone Number:

### Information about My Child

My Child's favorite toys:

Unique words/phrases my child uses:

Foods my child likes or is permitted and mealtimes:

Foods my child does not like or cannot eat:

TV shows my child can watch:

My child's favorite activities:

Activities I do not wish my child to do:

My child's sleep habits and nap/bedtimes:

My child's fears are:

Guidelines I use in letting my child use the computer or other similar devices:

Other information that will help you provide loving, good care:

### Health Information about My Child

My child has allergies:      Yes                  No                  If yes, please describe.

Allergy                          Reaction

My child has asthma:      Yes                  No                  If yes, please describe condition and medical treatment.

My child has a health condition:                      Yes                      No                      If yes, please describe condition and how it is treated.

My child takes medicine currently, either prescribed or over-the-counter:                      Yes                      No  
If yes, please describe.

Name	Purpose	Dose/Time
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Other relevant health information is:

### Emergency Information

**If I cannot be reached, contact:**

Name:

Relationship:

Location:

Work Telephone Number:

Cell Telephone Number:

Other Telephone Number:

**A neighbor who can be contacted in an emergency:**

Name:

Address:

Home Telephone Number:

Cell Telephone Number:

Other Telephone Number:

Our 911 address is

Direction to our home is:

## Medical/Professional Emergency Personnel

The name of my child's **physician**:

Telephone Number:

The name of my child's **dentist**:

Telephone Number:

**Other health care provider:**

(Field of Practice):

Telephone Number:

Preferred **hospital**

Telephone Number:

Address of hospital

**Fire department**

Telephone Number:

Preferred **ambulance**

Telephone Number:

## Other important numbers

Organization

Telephone Number

Poison Control

## My child's health insurance information

Provider:

Insured's Name and ID#:

Group ID#:

Policy ID#