CHILD ENROLLMENT FORMS

CLASSROOM: _____

START DATE: _____

DROP DATE: _____

Please fill this application completely. Accurate information is necessary in order to provide the best service for your child. It is your responsibility to notify us immediately of any changes in employment or residence. / Favor de completar esta aplicación. La información requerida es necesaria para que podamos servirle mejor a su hijo(a). Es su responsabilidad de notificarnos de cualquier cambio de trabajo o residencia.

Date/Fecha: _____ **Starting Date**/Fecha de comienzo: _____

Child's Name /Nombre del niño: _____

Gender/Género: ☐ **Male**/Masculino ☐ **Female**/Femenino

Date of Birth/Fecha de nacimiento: _____ **Age or Month's**/Edad o meses: _____

Allergies/Alergias: ☐ Asthma ☐ Food ☐ Medication ☐ Others/ Otros : _____

Explain any special need/Explique la necesidad especial: _____

_____

Mother's or Guardian's name/Nombre de la madre o Guardian:

_____

Address /Dirección: _____ **City**/Ciudad: _____

State/Estado: _____ **Zip Code**/Código postal: _____

Home Phone/Teléfono del hogar: _____ **Cellphone** /Celular: _____

Work Phone /Teléfono del trabajo: _____ **Other**/Otro: _____

Father's or Guardian's name/Nombre del padre o Guardian:

_____

Address/Direccion: _____ **City**/Ciudad: _____

State/Estado: _____ **Zip Code**/Código postal: _____

Home Phone/Teléfono del Hogar: _____ **Cellphone**/Celular: _____

Work Phone /Teléfono del trabajo: _____ **Other**/Otro: _____

Child's health care provider Information/Informacion del proveedor de salud del niño(a):

Name of clinic or Professional/Nombre de clínica o profeccional:

_____

Address/Dirección: _____ **City**/Ciudad: _____

State/Estado: _____ **Zip code**/Código postal: _____

Phone/Teléfono: _____ **Fax number**/Numero de Fax: _____

Time your child will be at the center/Horario en el cual su hijo(a) atenderá al centro:

Dates/Días	**Hour of Entrance**/Hora de entrada	**Hour of Exit**/Hora de salida
Monday/Lunes		
Tuesday/Martes		
Wednesday/Miércoles		
Thursday/Jueves		
Friday/Viernes		

EMPLOYMENT OR SCHOOL/EMPLEO O ESCUELA

The center must be able to reach a parent in case of an EMERGENCY or if your child changes behavior or needs additional help. Please provide parent's work or school information. Keep Director informed of any changes.

En caso de una emergencia o si el comportamiento de su niño(a) cambia o necesitamos alguna ayuda adicional el centro debe de lograr comunicarse con los padres. Favor de proveer la información de su empleo o escuela. Mantenga al Director informado de cualquier cambio.

Mother's or Guardian's name of employment or school/Nombre del empleo o escuelas de la madre o Guardian: _____

Address/Dirección: _____ **City**/Ciudad: _____

State/Estado: _____ **Zip Code**/Código postal: _____

Work Phone/Teléfono del trabajo: _____ **Other**/Otro: _____

	Monday/Lunes	**Tuesday**/Martes	**Wednesday**/Miércoles	**Thursday**/Jueves	**Friday**/Viernes
Work Hours/Horas del trabajo:					

Father's or Guardian's name of employement or school/Nombre del empleo o escuela del padre o Guardian:

_____

Address/Dirección: _____ **City**/Ciudad: _____

State/Estado: _____ **Zip Code**/Código postal: _____

Work Phone/Teléfono del trabajo: _____ **Other**/Otro: _____

	Monday/Lunes	**Tuesday**/Martes	**Wednesday**/Miércoles	**Thursday**/Jueves	**Friday**/Viernes
Work Hours/Horas del trabajo:					

Members of the household, their relationship to the child and their age/Miembros d
la familia inmediata, su edad y relacion al niño(a):

Names/Nombres	**Relationship**/Relación	**Age**/Edad

INFORMATION OF CHILD/INFORMACION DEL NIÑO(A)

1. **Has your child previously attended a daycare center?**/¿Ha asistido a una guardería su hijo(a) anteriormente?: ☐ **Yes**/Si ☐ **No**/No
2. **If yes, name of daycare**/Si atendió nombre la guardería: _____
   City/Ciudad: _____
3. **How long did the child attend?**/¿Por cuánto tiempo el niño(a) atendió?:
   _____

TOILET HABITS/HÁBITOS DEL USO DEL BAÑO

1. **Is your child currently potty trained?**/¿Esta su hijo(a) entrenado a usar el baño?:
   ☐ **Yes**/Si ☐ **No**/No
2. **Does your child still use one of the following?**/¿Aún su hijo(a) utiliza alguno de los siguientes?
   ☐ **Diapers**/Pañales ☐ **Pull ups**/Entrenadores
3. **Can your child indicate his bathroom needs?**/¿Puede su niño(a) identificar sus necesidades d
   baño?: ☐ **Yes**/Si ☐ **No**/No

SLEEPING HABITS/HÁBITOS DE DORMIR

1. **What time does your child go to bed?**/¿A qué hora va su niño(a) a la cama?: _____
2. **What time does your child wake up?**/¿A qué hora se despierta su niño(a)?: _____
3. **Does the child have their own room?**/¿Tiene su niño(a) su propio dormitorio?:
   ☐ **Yes**/Si ☐ **No**/No
4. **Does your child take naps?**/¿Toma su niño(a) siesta?: ☐ **Yes**/Si ☐ **No**/No
   Time/Hora: _____

SOCIAL RELATIONSHIPS/RELACIONES SOCIALES

1. **Does your child spend time with both parents?**/¿Pasa su niño(a) tiempo con ambos padres?

   ☐ **Yes**/Si ☐ **No**/No

2. **If you are separated, how often does the child see the absent parent?**/¿Si estan separados cuanto tiempo pasa el niño con el padre ausente?: _____

3. **Is your child naturally**/Es su niño(a) naturalmente:

   ☐ **Friendly**/Amistoso ☐ **Aggressive**/Agresivo ☐ **Shy**/Timido ☐ **Withdrawn**/Introvertido

4. **Has your child had experience in playing with other children?**/¿ Ha tenido su niño(a) experiencia jugando con otros niños?: ☐ **Yes**/Si ☐ **No**/no

5. **How does your child express his feelings?**/¿ Como su niño(a) expresa sus sentimientos?: _____

6. **What is your child scared or frightened of?**/¿ A que le tiene miedo o terror su niño(a)?: _____

FOOD AND EATING HABITS/HABITOS DE COMIDA Y ALIMETICIOS:

1. **Does your child have food allergies?**/¿Tiene su niño(a) alergias a algún alimento?:

   ☐ **Yes**/Si ☐ **No**/No **Explain**/Explique: _____

2. **What are your child's favorite foods?**/¿Cuáles la comida favorita de su niño(a)?: _____

3. **What food does you child dislike most?**/¿Cuáles la comida que su niño(a) no le gusta?: _____

****

If the information above is correct please sign/Si la informacion arriba es correcta favor de firmar.

SIGNATURE/FIRMA:_____ **DATE**/FECHA:_____

CHILD HEALTH HISTORY PRIOR TO ENROLLMENT

PRELIMINARY QUESTIONS

How much did this child weigh at birth? ☐ Weight Status at Birth: ☐

Has anyone in the family ever had any serious illnesses or abnormalities (e.g. heart disease, diabetes, tuberculosis, asthma, etc.)? If yes, please explain. ☐Yes ☐No

Were there any problems with this child immediately after birth? If yes, please explain. ☐Yes ☐No

Is your child taking any medications every day? If yes, please explain. ☐Yes ☐No

Will medication be needed at school? If yes, please explain. ☐Yes ☐No

HAS THIS CHILD EVER HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE GIVE DATE AND EXPLAIN BELOW

☐ Measles		☐ Ear/Nose/Throat Problems		☐ Eye Problems	
☐ Mumps		☐ Urinary/Kidney Problems		☐ Heart Disease	
☐ Chickenpox		☐ Muscle/Bone Problems		☐ Pneumonia	
☐ Scarlet Fever		☐ Anemia		☐ Asthma	
☐ Respiratory		☐ Blood Pressure		☐ Diabetes	
☐ Tuberculosis		☐ Rheumatic Fever		☐ Intestinal Problems	
☐ Seizures		☐ Bee Sting Allergy			

COMMENTS:

HAS YOUR CHILD EVER HAD THE FOLLOWING? IF YES, PLEASE GIVE DATE AND EXPLAIN.

☐ Hospitalizations----------

☐ Operations----------

☐ Serious Injuries----------

☐ Other Health Problems-------

☐ Allergies to Medications------

DEVELOPMENTAL HISTORY: DID CHILD...

- ☐ Focus eyes and follow light or objects with eyes by 2 months?
- ☐ Coo and Gurgle by 3 to 4 months?
- ☐ Sit alone on or before the 8th month?
- ☐ Say simple words on/or before 15th month?
- ☐ Toilet train on/or before the 3rd year?
- ☐ Mental development appears normal?

EXPLAIN/COMMENTS: _____

IMMUNIZATION HISTORY

☐ Is child up to date on all immunizations appropriate for his/her age?

☐ Has child received all immunizations possible at this time but has not received all immunizations appropriate for his/ her age?

☐ Has received no immunizations.

☐ None of the above.

DENTAL INFORMATION

Does the child have an Ongoing Source of Continuous and Accessible Dental Car?
Dentist Name: _____ Date of last visit: _____
Were there any problems for the child/comments:

_____

NUTRITION ASSESMENT

☐Yes ☐No **1.** Does your child's weight appear normal?

☐Yes ☐No **2.** Does your child eat fruits and vegetables?

☐Yes ☐No **3.** Is your child a picky eater?

☐Yes ☐No **4.** In the past six months, was your child found to be anemic (low blood iron)?

☐Yes ☐No **5.** Is your child involved in active play daily?

☐Yes ☐No **6.** Does your child have diarrhea frequently?

☐Yes ☐No **7.** Does your child have constipation frequently?

☐Yes ☐No **8.** Does your child vomit frequently?

☐Yes ☐No **9.** Does your child drink from a baby bottle now?

☐Yes ☐No **10.** Does your child have dental problems now?

☐Yes ☐No **11.** Does your child have difficulty chewing or swallowing now?

☐Yes ☐No **12.** Do you have concerns about your child's growth, nutrition or eating/?

How often does your child eat these foods? Please check the number of times per day your child eats these foods

FOOD GROUPS	1	2	3	4	5
Milk Group: Milk (Whole, 2%, 1%, skim) yogurt, cheese, milkshakes)					
Meat, Poultry, Fish, Dry Beans, Eggs: Beef, chicken, turkey, pork, fish, eggs, peanut butter, Nut Group: dried beans, nuts, peas, lentils					
Bread, Cereal, Rice & Pasta Group: Bread (all kinds), hot or cold cereal, crackers, tortillas, noodles or pasta (all kinds), rice					
Vitamin C Rich Group: Orange, grapefruit, lemon, lime, strawberries, tangerine, watermelon, mangoes, tomatoes, cabbage					
Other fruits & Vegetables Group: Apple, banana, pear, grape, peach, potato, green beans, corn					
Vitamin A Rich Group (per week): Dark green or orange vegetables & fruits such as greens, carrots, broccoli, winter squash, spinach, pumpkin, sweet potato					
Fatty Foods: (a) Bacon, lunch meat, sausage, hot dogs, fried foods (b) butter/margarine, sour cream, regular salad dressings, mayonnaise					
Soda and Flavored Drinks: Pop, kool aid, fruit drinks					
Sugar and Sweets: Candies, cake, cookies, high sugar cereals					
Salty Snacks: Chips, salted pretzels, pickles					

FOOD SUBSTITUTION

☐Yes ☐No	Is your child restricted from foods due to religious, vegetarian, medical, or personal beliefs? If yes, Please check all that apply: ☐ Pork ☐ Beef ☐ Poultry ☐ Fish ☐ Eggs ☐ Milk ☐ Other:_____
☐Yes ☐No	Does your child have any food allergies or intolerances? If yes, please check all that apply: ☐ Milk ☐ Milk Products ☐ Eggs ☐ All food containing eggs ☐ Whole Wheat ☐ Shellfish ☐ Beef ☐ Legumes (Dry Beans/Peas) ☐ Tree Nuts/Seeds ☐ Peanuts ☐ Soy ☐ Vegetables, specify:_____ ☐ Fruits/Juice, specify: _____ ☐ Other, specify:_____ What kind of reaction does your child have when your child eats the specified food? ☐ Life Threatening ☐ Rash ☐ Diarrhea ☐ Swelling ☐ Difficulty Breathing ☐ Other:_____
☐Yes ☐No	Is your Child on any special diet prescribed by a doctor? If yes, specify _____ _____
	NOTE TO STAFF: Is yes to question 2, 3, and/or 4 above-staff must give parent individual health plan to fill out and return to center. NOTE: substitutions for non-medical reasons (I.e. religious, vegetarian, etc.) will be approved on a case by case with the nutrition manager or nutritionist. Substitutions for medical reasons will be accommodated only with individual health plan filled out by a licensed physician or other medical authority.

ASTHMA / ALLERGY SCREENING

□Yes □No	Has your child ever been diagnosed by a medical professional as having asthma? a) Date of diagnosis:_____ b) How many episodes per year?_____ c) Is it seasonal? At what time of the year do the episodes most often occur? _____ d) Is it well controlled? How? _____
□Yes □No	Has your child experienced any of the following due to asthma? If yes, please check all that apply: □ Treatment in ER If yes, then # of times:_____ □ Hospitalizations If yes, then # of times:_____
□Yes □No	Have you ever given your child any medications for asthma? If yes, please check all that your child ha **used in the last year:** □ Albuterol □ Intal □Ventolin □ Pedia Pred □ Tedral □ Prelone □ Proventil □ Primitine Mist □ Marax □ Quiboron □ Other:_____
□Yes □No	Does your child use a Nebulizer or Inhaler? How many colds does your child have in a year? _____
□Yes □No	Does your child suffer from hay fever or eczema?
□Yes □No	Is your child allergic to any of the following? If yes, please check all that apply: □ Animals □ Perfume □ Birds □ Pollen □ Grass □ Flowers □ Dust □ Trees □ Smoke □ Weather Changes □ Other:_____
□Yes □No	Does anyone in the household smoke? (I.e. home/car)

LEAD POISONING SCREENING

☐Yes ☐No 1. Is paint peeling or chipping on any part of your house?

☐Yes ☐No 2. Is your house being remodeled?

☐Yes ☐No 3. Has your child or anyone in your family been treated or monitored for lead poisoning? (I.e. blood lead)

☐Yes ☐No 4. Does your child live with someone whose job or hobby involved exposure to lead? (I.e. painting, sold automobile battery manufacturing or recycling, vehicle radiator repair, auto painting, or stained glass)

☐Yes ☐No 5.Do you or anyone else who lives with or cares for your child use Azarcon, Greta, Rueda, Coral, Alca María Luisia?

☐Yes ☐No 6. Do you use pottery (ceramics, earthenware) that is old or has been bought outside the US for cooking, drinking or storing food?

☐Yes ☐No 7. Does your family buy canned food or packed candles from other countries?

☐Yes ☐No 8. Does your child eat dirt or clay or other non-food items?

☐Yes ☐No 9. Does your child or family travel outside the US?

MEDICAL COVERAGE

Child Receives Medical Services through Ongoing Source of Continuous, Accessible Medical Care

□Yes □No	Does your family have a regular doctor or a regular place to receive health services? If yes, please answer the following: Doctors Name: _____ Address: _____ Phone Number: _____ **Date of Physical:** _____
	If no, please answer the following: Medical Home intervention □ Medicaid □ Private Health Insurance □ Indian Health Services □ Migrant Community Health Centers □ Other: _____
□Yes □No	Do you use the Cook County Hospital health services? If yes, what city? _____ Date of last physical: _____

HEALTH HISTORY CONSENTS SECTION

☐Yes ☐No **1.** Dental screening/exam and treatments (to detect problems with teeth and gums)

☐Yes ☐No **2.** Vision screening/exam (to detect problems with vision)

☐Yes ☐No **3.** Auditory/Hearing screening (to detect problems with the ears)

☐Yes ☐No **4.** Blood pressure screenings (if not noted on the physical exam)

☐Yes ☐No **5.** Nutrition/growth screening and referral (to detect problems with delayed growth/overweight/underweight children)

☐Yes ☐No **6.** Speech and language screenings (to detect problems with speaking and understanding)

☐Yes ☐No **7.** Developmental screening (to assess levels in language, cognition, visual, small motor, gross motor, emotional aspects)

☐Yes ☐No **8.** Behavioral observations (to further assess social and emotional development)

☐Yes ☐No **9.** In cases of emergency medical/dental care, I give permission to the center's staff To secure needed medical care if parents/guardian cannot be immediately contacted.

☐Yes ☐No **10.** That necessary health information concerning my child may be released to the appropriate agencies. To the care of my child and the school my child will be attending after Childcare.

☐Yes ☐No **11.** Blood test to check lead levels and/or anemia, if no results are available

COMMENTS: _____

Enrollment Coordinator Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

DISCIPLINE / DISCIPLINA

I understand that it is the policy of this childcare center to provide discipline that is developmentally related to the child's behavior shall not be out of proportion to the particular inappropriate behavior. Removal from the group as a means of helping a pre-school child gain control shall be for periods not to exceed one minute per year of age. The Director reserves the right to exclude any child from the classroom or center due to behavior that may jeopardize the health and safety of the individual and the group.

Yo entiendo que es la póliza del cuidado de niños a proveer disciplina que sea apropiada para el desarrollo del niño y relacionada a la reacción del niño del grupo con un debería excederse de la proporción a una conducta inapropiada. Remover el niño del grupo con un propósito de ayudar al preescolar a obtener su control, no deber a excederse por un periodo de un minuto de a la edad del niño. El director se reserva el derecho a excluir a cualquier niño del salón o del centro por su comportamiento el cual ponga en peligro la salud y seguridad del individuo o el grupo.

Parent Signature / Firma del padre: _____

Date / Fecha: _____

CONFIDENTIALITY OF INFORMATION / CONFIDENCIALIDAD DE INFORMACION

I understand under the childcare policy on confidentiality of the records, I have the right to examine my child's file up to five years after his withdrawal date. I also give permission of access my child's records to the Director and staff of this center. I understand that copies of this information will be given to me at my written request.

Yo entiendo la póliza del cuidado de niños sobre la confidencialidad de los expedientes. Yo entiendo que tengo el derecho de examinar los registros de mi hijo(a) hasta cinco años después de su retiro. Yo también doy permiso al acceso del expediente de mi hijo(a) al Director y el equipo de este centro. Yo entiendo que copias de esta información se me serán facilitadas con mi petición por escrito.

Parent Signature / Firma del padre: _____

Date / Fecha: _____

...REEMENT FORM / FORMA DE PERMISO Y ACUERDO

MEDICAL RELEASE / CONSENTIMIENTO DE ASISTENCIA MÉDICA:

I give authorization for my child to receive medical treatment in case of illness, accident, or injury requiring emergency medical care, while attending the childcare center.

Yo doy mi autorización para que mi hijo(a) (¿) tratamiento médico, en caso de enfermedad, accidente, o golpe que requiere cuidado de emergencia médica, mientras él/ella está asistiendo al centro de cuidado de niños.

MEDICAL ADMINISTRATION / ADMINISTRAMIENTO DE MEDICAMENTO:

I give authorization to this center to administer prescribed medication to my child as specified on the written instructions on the medication label. I'm informed that I will need to fill out a medication administration form, giving permission to the center's staff to administer medication to my child. I understand that the childcare center and the staff is not responsible for any reaction that this medication my cause to my child. I'm informed that no medication purchased over the counter will be accepted.

Yo doy mi autorización a este centro a administrarle medicamento prescrito a mi hijo(a) como es especificado en las instrucciones escritas en la etiqueta. Estoy informado que necesito completar una forma de administración de medicamentos dándole permiso al equipo del centro a administrarle medicamento a mi hijo(a). *Yo entiendo que el centro de cuidado de niños y el equipo no es responsable de ninguna* reacción que este medicamento le cause a mi hijo(a). Estoy informado que no se acepta ningún medicamento comprado en el mostrador.

TRIP RELEASE / CONSENTIMIENTO DE EXCURSIONES:

I give permission for my child to go for walks off premises of the center, trips to the park and any *other activities that are involved outside of the center. That is developmentally appropriate.* I understand that these are organized and supervised by childcare center staff.

Yo doy permiso para que mi hijo(a) salga a caminar fuera de las instalaciones del centro, paseos al parque y otras actividades que envuelvan fuera del centro. Que sean apropiadas para el desarrollo. Yo también entiendo que son organizadas y supervisadas por el equipo del centro.

PHOTOGRAPHS RELEASE / CONSENTIMIENTO DE FOTOGRAFIAS

I give authorization for my child to be photographed by any of the center's staff. I understand that these photos will be used in classroom activities and decorations. I'm also informed that these photographs of the child may appear in newspaper, magazines, brochures or other publicity materials. I understand that my permission for photographs of my child may be used without compensation as part of this agreement.

Yo doy autorización a que mi hijo(a) sea fotografiado por el equipo del centro. Yo entiendo que estas fotos serán utilizadas para actividades del salón y decoración. Yo estoy informado que estas fotos de mi hijo(a) pueden aparecer en periódicos, revistas o volantes u otros materiales públicos. Yo también entiendo que mi permiso para estas fotografías de mi hijo(a) pueden ser utilizadas sin ninguna recompensa como parte de *este acuerdo.*

Child's Name: / Nombre del niño(a): _____

Parent Name: / Firma del Padre: _____

Date: / Fecha: _____

EMERGENCY CONTACT AND AUTHORIZATION TO RELEASE CHILD FORM

Child's Name: _____ Date of Birth: _____ Gender: F ☐ M ☐

Allergies: ☐ Medication ☐ Food ☐other (specify) _____

Especial treatment: _____

Mother / Guardian: _____

Address: _____

Home phone # _____ Cell phone # _____

Work phone # _____ other phone #. _____

Father / Guardian: _____

Address: _____

Home phone # _____ Cell phone # _____

Work phone # _____ other phone # _____

Doctor: _____

Address: _____

Phone #: _____

In case of an emergency your child will be accompany by Site Director or Assist. Director to the nearby emergency room until the parent show up

Saint Anthony Hospital
2875 W 19th Street
(773) 484-1000

EMERGENCY CONTACTS / AUTHORIZE PERSON TO PICK UP MY CHILD

Name	Phone #	Address	Relationship

By signing this document I authorize the above person(s) to pick up my child from the Childcare Center. I understand that my child will not be released to an unauthorized person(s) until my direct permission is received. I understand that pick up person needs to be 18 yrs. of age or oldest.

I give permission to the childcare center to make whatever emergency (first Aid, disaster and evacuation, and field trips) or any measures and judged necessary for your child's care and protection while under the supervision of the center.

In case of a medical emergency, I understand that my child will be transported to the near hospital by local emergency unit treatment. It is understood that in some medical situation the staff will need to contact the local emergency resources **911** before the parent, after that the parent will be call ed immediately and contacted person in their order if is necessary. If you have any question please bring it to the office personal and always keep this record update at all times.

Parent / Guardian Signature: _____ Date: _____

FORMA DE CONTACTO DE EMERGENCIA Y AUTHORIZACION PARA RECOGER EL NIÑO

Nombre del niño: _____ Fecha de nacimiento: _____ Sexo: F ☐ M ☐

Alergias: ☐ Medicamento ☐ Alimento ☐otros (especifique) _____

Tratamiento especial: _____

Madre / Guardian: _____

Dirección: _____

Teléfono de la casa # _____ Celular # _____

Teléfono del trabajo # _____ Otro Teléfono # _____

Padre / Guardián: _____

Dirección: _____

Teléfono de la casa # _____ Celular # _____

Teléfono del trabajo # _____ Otro Teléfono # _____

Doctor: _____
Direccion: _____

Teléfono #: _____

En caso de emergencia su hijo(a) será acompañado por la Directora o la Asistente de Directora al centro de emergencia más cercano hasta que el padre se presente.

Saint Anthony Hospital
2875 W 19th Street
(773) 484-1000

CONTACTOS DE EMERGENCIA / AUTORIZADOS A RECOGER MI NIÑO(a)

Nombre	Teléfono #	Dirección	Relación

Al firmar este documento yo autorizó a las personas marcadas arriba a recoger my hijo(a) del Centro de cuidado de niños. Yo entiendo que mi hijo(a) no será recogido por una persona no autorizada asta que mi permiso directo sea recibido. Yo entiendo que la persona que recogerá mi hijo necesita tener 18 años de edad o más.
Doy permiso a centro de cuidado de niños a hacer cualquier emergencia necesaria (Primeros Auxilios, Evacuaciones de desastres, paseos) a cualquier medida justificada para proteger y cuidar el niño(a) mientras este bajo la supervisión del centro.
En caso de emergencia médica, yo entiendo que my hijo(a) será transportada al hospital mas cercano al centro por la unidad de tratamientos de emergencia. Es entendible que en algunas situaciones médicas el personal necesitara contactar al recurso de emergencia 911 antes que a los padres. Luego los padres serán contactados inmediatamente y las personas de contacto en su orden si es necesario. Si tiene alguna pregunta por favor tráigala a nuestra atención al personal de la oficina y siempre mantenga este record al día en todo momento.

Firma de Padre / Guardián: _____ Fecha: _____