

# CHILD ENROLLMENT APPLICATION

Please fill this application completely. Accurate information is necessary 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 servir mejor a su hijo(a). Es su responsabilidad de notificarnos de cualquier cambio de residencia o trabajo.

Date/Fecha: \_\_\_\_\_

## CHILD'S INFORMATION / INFORMACION DEL NINO (A)

Child's name / Nombre del niño(a): \_\_\_\_\_

Gender / Genero:  Male / Masculino  Female / Femenino

Date of Birth / Fecha de Nacimiento: \_\_\_\_\_ Age or Months / Edad o Meses \_\_\_\_\_

Any health conditions / Alguna condicion medica: \_\_\_\_\_

Allergies / Alergias:  Asthma / Asma  Food / Comida  Others / Otros.

Does your child suffer from Eczema / Sufre su niño(a) de Eczema:  Yes / Si  No / No

Explain any health conditions or special needs / Explique la condición de salud o necesidad especial:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PARENT'S OR GUARDIAN'S INFORMATION / INFORMACION DE LOS PADRES O GUARDIAN:

Mother's name / Nombre de la Madre / Guardian's name / Nombre del Guardian:

\_\_\_\_\_  
Address /Dirección: \_\_\_\_\_ City/Ciudad: \_\_\_\_\_

State/Estado: \_\_\_\_\_ Zip Code/Código postal: \_\_\_\_\_

Contact Number / Numero de Contacto \_\_\_\_\_

Email Adress / Correo Electrónico: \_\_\_\_\_

Father's Name / Nombre de la Padre / Guardian's Name / Nombre del Guardian:

\_\_\_\_\_  
Address /Dirección: \_\_\_\_\_ City/Ciudad: \_\_\_\_\_

State/Estado: \_\_\_\_\_ Zip Code/Código postal: \_\_\_\_\_

Contact Number / Numero de Contacto \_\_\_\_\_

Email Adress / Correo Electrónico: \_\_\_\_\_

**HEALTH CARE PROVIDER INFORMATION:**

Health care Provider Name / Nombre del proveedor de salud:

Address/Dirección: \_\_\_\_\_

Phone Number / Numero telefónico: \_\_\_\_\_

**Schedule for childcare services / Horario para servicio de cuidado infantil:**

**DATES NEEDED / DIAS NECESARIOS:**

MONDAY     TUESDAY     WEDNESDAY     THURSDAY     FRIDAY

**FULL WEEK / SEMANA COMPLETA:**

MONDAY THROUGH FRIDAY / DE LUNES A VIERNES

**HOURS OF SERVICE NEEDED / HORARIOS NECESARIOS DE SERVICIO:**

Drop off / Entrada: \_\_\_\_\_ AM. Pick up / Salida: \_\_\_\_\_ PM.

**EMPLOYMENT / SCHOOL INFORMATION - INFORMACION DE EMPLEO / 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.

Mother's / Guardian's Employment or School – Madre / Guardian Empleo o Escuela:

Address /Dirección: \_\_\_\_\_ City/Ciudad: \_\_\_\_\_

State/Estado: \_\_\_\_\_ Zip Code/Código postal: \_\_\_\_\_

Phone Number / Numero de teléfono \_\_\_\_\_

|   | Monday/Lunes | Tuesday/Martes | Wednesday/Miércoles | Thursday/Jueves | Friday/Viernes |
|---|--------------|----------------|---------------------|-----------------|----------------|
| Work Hours/Horas del trabajo - Horarios de trabajo / Escuela: |              |                |                     |                 |                |

Father's / Guardian's Employment or School – Padre / Guardian Empleo o Escuela:

Address /Dirección: \_\_\_\_\_ City/Ciudad: \_\_\_\_\_

State/Estado: \_\_\_\_\_ Zip Code/Código postal: \_\_\_\_\_

Phone Number / Numero de teléfono \_\_\_\_\_

|   | Monday/Lunes | Tuesday/Martes | Wednesday/Miércoles | Thursday/Jueves | Friday/Viernes |
|---|--------------|----------------|---------------------|-----------------|----------------|
| Work Hours/Horas del trabajo - Horarios de trabajo / Escuela: |              |                |                     |                 |                |

**FAMILY MEMBERS THAT ARE IN THE HOUSEHOLD / MIEMBROS DE LA FAMILIA QUE RESIDEN EN EL HOGAR.**

| <b>Names/Nombres</b> | <b>Relationship/Relación</b> | <b>Age/Edad</b> |
|----------------------|------------------------------|-----------------|
|                      |                              |                 |
|                      |                              |                 |
|                      |                              |                 |
|                      |                              |                 |
|                      |                              |                 |
|                      |                              |                 |
|                      |                              |                 |

**INFORMATION OF CHILD/INFORMACION DEL NIÑO(A)**

1. Has your child previously attended a daycare? / ¿Ha asistido a una guardería su Hijo (a) anteriormente?  Yes/Si  No/No

If Yes, Name of daycare: / Si es Si, Nombre de la guardería: \_\_\_\_\_

Address / Dirección: \_\_\_\_\_

2. How long did the child attend? / ¿Por cuánto tiempo asistió el niño(a)? \_\_\_\_\_

**TOILET HABITS/HÁBITOS DEL USO DEL BAÑO**

3. Is your child currently potty trained? / ¿Está su hijo(a) entrenado(a) a usar el baño?

Yes/Si  No/No

4. Does your child still use one of the following? / ¿Aún utiliza su hijo(a) alguno de los siguientes?

Diapers/Pañales  Pull ups/Entrenadores  Underwears only / Solo ropa interior

5. Can your child indicate his bathroom needs? / ¿Puede su niño(a) identificar sus necesidades de baño?  Yes/Si  No/No

Other Explain / Otros explique: \_\_\_\_\_

**SLEEPING HABITS/HÁBITOS DE DORMIR**

6. What time does your child go to bed? / ¿A qué hora va su niño(a) a la cama? \_\_\_\_\_

7. What time does your child wake up? / ¿A qué hora se despierta su niño(a)? \_\_\_\_\_

8. Does the child have their own room? / ¿Tiene su niño(a) su propio dormitorio?

Yes/Si  No/No

9. Does your child take naps? / ¿Toma su niño(a) siesta?  Yes/Si  No/No

Time/Hora: \_\_\_\_\_

## SOCIAL RELATIONSHIPS/RELACIONES SOCIALES

10. Does your child spend time with both parents? / ¿Pasa su niño(a) tiempo con ambos padres?  
 Yes/Si     No/No
11. If you are separated, how often does the child see the absent parent? / ¿Si están separados cuánto tiempo pasa el niño con el padre ausente? \_\_\_\_\_
12. Is your child naturally? / ¿Es el niño(a) naturalmente?  
 Friendly/Amistoso     Aggressive/Agresivo     Shy/Tímido     Withdrawn/Introvertido
13. Has your child had experience in playing with other children? / ¿Ha tenido su niño(a) experiencia jugando con otros niños?  Yes/Si     No/No
14. How does your child express his feelings? / ¿Cómo su niño(a) expresa sus sentimientos?  
\_\_\_\_\_
15. What is your child Scared or frightened of? / ¿Aque le tiene miedo o terror su niño(a)?  
\_\_\_\_\_

## FOOD AND EATING HABITS/HABITOS DE COMIDA Y ALIMENTICIOS:

16. Does your child have any food allergies or restrictions due to health or religion? / ¿Tiene su niño(a) alergias o restricciones a algun alimento por salud o religion?  
 Yes/Si     No/No

Explain/Explique:  
\_\_\_\_\_

17. What kind of reaction does your child have when eats any specified food? ¿Qué tipo de reacción tiene el niño(a) cuando come una comida en específico?

- Life Threateing / Pone en riesgo su vida     Rash / Alergia     Diarrhea / Diarrea  
 Swelling / hinchazón     Difficulty Breathing / Dificulta para respirar  
 Others Specify: / Otros especifique: \_\_\_\_\_

18. What are your child's favorite foods? / Cuales la comida favorita de su niño(a)?  
\_\_\_\_\_

19. What food does your child dislike most? / Cuales la comida que su niño(a) no le gusta?  
\_\_\_\_\_

20. Is your child on any special diet prescribe by doctor? /Esta su niño(a) en alguna dieta específica por el Doctor?

Yes / Si     No / No    Explain / Explique: \_\_\_\_\_

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PARENT/GUARDIAN SIGNATURE/

FIRMA DEL PADRE/GUARDIAN: \_\_\_\_\_ DATE/FECHA: \_\_\_\_\_

# CHILD HEALTH HISTORY PRIOR TO ENROLLMENT

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 medication 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

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| <input type="checkbox"/> Measles       |  | <input type="checkbox"/> Ear/Nose/Throat Problems |  | <input type="checkbox"/> Eye Problems        |  |
| <input type="checkbox"/> Mumps         |  | <input type="checkbox"/> Urinary/Kidney Problems  |  | <input type="checkbox"/> Heart Disease       |  |
| <input type="checkbox"/> Chickenpox    |  | <input type="checkbox"/> Muscle/Bone Problems     |  | <input type="checkbox"/> Pneumonia           |  |
| <input type="checkbox"/> Scarlet Fever |  | <input type="checkbox"/> Anemia                   |  | <input type="checkbox"/> Asthma              |  |
| <input type="checkbox"/> Respiratory   |  | <input type="checkbox"/> Blood Pressure           |  | <input type="checkbox"/> Diabetes            |  |
| <input type="checkbox"/> Tuberculosis  |  | <input type="checkbox"/> Rheumatic Fever          |  | <input type="checkbox"/> Intestinal Problems |  |
| <input type="checkbox"/> Seizures      |  | <input type="checkbox"/> Bee Sting Allergy        |  |  |  |

COMMENTS: \_\_\_\_\_

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

|   |                      |
|---|----------------------|
| <input type="checkbox"/> Hospitalizations -----         | <input type="text"/> |
| <input type="checkbox"/> Operations -----               | <input type="text"/> |
| <input type="checkbox"/> Serious Injuries -----         | <input type="text"/> |
| <input type="checkbox"/> Other Health Problems -----    | <input type="text"/> |
| <input type="checkbox"/> Allergies to Medications ----- | <input type="text"/> |

## 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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## 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.

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## DENTAL INFORMATION

Does the child have an Ongoing Source of Continuous and Accessible Dental Care?

Dentist Name: \_\_\_\_\_ Date of last visit \_\_\_\_\_

Were there any problems for the child/comments:

\_\_\_\_\_

\_\_\_\_\_

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

**FOOD SUBSTITUTION**

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is your check child restricted from foods due to religious, vegetarian, medical, or personal beliefs? If yes, please check all that apply:<br><input type="checkbox"/> Pork <input type="checkbox"/> Beef <input type="checkbox"/> Poultry <input type="checkbox"/> Fish <input type="checkbox"/> Eggs <input type="checkbox"/> Milk <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does your child have any food allergies or intolerances? If yes, please check all that apply:<br><input type="checkbox"/> Milk <input type="checkbox"/> Milk Products <input type="checkbox"/> Eggs <input type="checkbox"/> All food containing eggs <input type="checkbox"/> Whole Wheat<br><input type="checkbox"/> Shellfish <input type="checkbox"/> Beef <input type="checkbox"/> Legumes (Dry Beans/Peas) <input type="checkbox"/> Tree Nuts/Seeds <input type="checkbox"/> Peanuts<br><input type="checkbox"/> Soy <input type="checkbox"/> Vegetables, specify: _____ <input type="checkbox"/> Fruits/Juice, specify: _____<br><input type="checkbox"/> Other, specify: _____<br>What kind of reaction does your child have when your child eats the specified food?<br><input type="checkbox"/> Life Threatening <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Swelling <input type="checkbox"/> Difficulty Breathing<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is your Child on any special diet prescribed by a doctor? If yes, specify<br>_____<br>_____   |
|  | 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.<br><br>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

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

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does your family have a regular doctor or a regular place to receive health services? If yes, please answer the following:<br><br>Doctor Name: <input style="width: 90%;" type="text"/><br><br>Address: <input style="width: 90%;" type="text"/><br><br>Phone Number: <input style="width: 90%;" type="text"/><br><br><b>Date of Physical:</b> <input style="width: 90%;" type="text"/> |
|  | If no, please answer the following:<br>Medical Home intervention<br><input type="checkbox"/> Medicaid <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Indian Health Services<br><input type="checkbox"/> Migrant Community Health Centers <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use the Cook County Hospital health services?<br><br>If yes, what city? <input style="width: 90%;" type="text"/><br><br>Date of last physical: <input style="width: 90%;" type="text"/>  |

## 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

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**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 preschool 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 INFORMACION DE INFORMACION

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**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:** \_\_\_\_\_

## **PERMISSION AND AGREEMENT 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 newspapers, 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:** \_\_\_\_\_

**Parent Signature / 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 19<sup>th</sup> 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 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 / Guardián:** \_\_\_\_\_

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: \_\_\_\_\_

Dirección: \_\_\_\_\_

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.

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### 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: \_\_\_\_\_