DATE TO BEGIN:

____

GAYLORD COMMUNITY SCHOOLS
AFTER SCHOOL CHILD CARE
CHILD INFORMATION RECORD

Grade______________
School______________
Teacher______________

PLEASE FILL IN COMPLETELY ~ PLEASE PRINT CLEARLY IN INK

Today's Date ____________________ **Student's Legal Name** ______________________________________
Last First Middle

Gender □ **M** □ **F** **Birth date**____/______/______ **Home Phone**______________________________

Street Address______________________________ **Mailing Address**______________________________

City______________________________ **Zip Code**______________________________

Mother/Legal Guardian Name______________________________Home Phone (____)______________

Home Address (if not child's address)____

Mother Employer/School______________________________ Phone (_____)______________
Ext./Dept.

Daily Work/School Times____

Mother Email______________________________ Cell Phone (______)______________

Father/Legal Guardian Name______________________________ Home Phone (_____)______________

Home Address (if not child's address)____

Father Employer/School______________________________ Phone (_____)______________
Ext./Dept.

Daily Work/School Times____

Father Email______________________________ Cell Phone (______)______________

Names of All Adults Residing with Student: ______________________________________

Student Lives With: *(Please Check)*

_____ Both natural parents _____ Father only _____ Host family _____ Divorced-joint custody

_____ Father/Stepmother _____ Mother only _____ Relative _____ Adult student

_____ Mother/Stepfather _____ Legal guardian _____ Court placed

Student's Residence Is: *(Please Check)*

_____ Single Family Dwelling ______ More than 1 family in house/apartment

_____ Motel/Car/Campsite ______ Shelter______________________________

_____ With friends/family (other than parent/guardian)______________________________

_____ Other____

Other children residing in the home:

Name (Last, First)	**Birthdate**	**Grade**	**School Attending**

To the best of my knowledge, ______________________________________ is of good health, free of any communicable disease, and his/her immunizations are up to date. This health statement waives the need for my child to have a physical examination record on file for entry into this program.

______________________________ ______________________
Parent's Signature Date

MEDICAL INFORMATION

Allergies:

_____ **Food** *(Please List)*

_____ **Animals**
_____ **Medications**
_____ **Other**_____________

_____ **Asthma**
_____ **Diabetes**
_____ **Convulsions/seizures**
Please Explain________________________
_____ **Other**
Please Explain________________________

Medical Authorization and Authorization to Transport in Case of Emergency

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If the physician cannot be reached, the school may make necessary arrangements for the well being of my child.

Doctor's Name   Office Location   Address   Office Phone

Hospital Preferred for Emergency Treatment   Health Insurance Policy Number

Special Needs____

Date of Last DTap (Diptheria, tetanus, pertussis) Shot____

PERSONS AUTHORIZED TO PICK UP CHILD IN AN EMERGENCY

If your child is injured, ill or needs to leave the child care center, we will contact the parents listed on the front of this card first. If parents are unavailable, we will contact the following individuals authorized to pick up your child from school. Your child should know the person. ID may be requested.

Authorized Person   Relationship   Address

Home Phone   Cell Phone   Work Phone

Authorized Person   Relationship   Address

Home Phone   Cell Phone   Work Phone

Your child will not be released to any unauthorized person.

Special Instructions:

I request my child attend on:
Monday______ Tuesday______ Wednesday______ Thursday______ Friday______
Estimated Pick-up Time:____

- I affirm that as the parent/legal guardian, all information provided is true and accurate.
- I give permission to the Gaylord Community Schools Childcare Program, licensed by the Department of Human Services, to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.
- I have received and read the child care program information sheet. I understand the program will bill me on a monthly basis and it is my responsibility to make sure the statement is paid by the due date.
- I understand that if my child is in grades K-3, they will board a GCS school bus and be transported to the after-school child care program.

Signature of Parent/Guardian   **Date**

It is the policy of Gaylord Community Schools that no person shall, on the basis of race, color, religion, national origin or ancestry, gender, age, disability, height, weight, marital status or any other legally protected characteristic be excluded from participation in, be denied the benefits of, or be subjected to, discrimination during any program, activity, service or in employment. Inquiries should be addressed to: Civil Rights Coordinator, 615 S. Elm Street, Gaylord, MI, 49735, (989) 705-3080.

Date of Admission:

Date of Discharge: