



## CHILD'S RECORDS

Year: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Place of Employment: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Place of Employment: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### Emergency Contacts (other than parent):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

### Name of persons permitted to remove your child from the center:

Name: \_\_\_\_\_ Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Please Note that we are not able to release a child to any person other than his/her parent or guardian without written consent. Also, any person other than the parent/guardian must provide First Step with photo identification to remove the child from the center.**

### Family Physician:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

### Dentist:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

**PLEASE SEE REVERSE SIDE**

**Medical Information**

In the event of a medical emergency, When I cannot be reached I hereby give consent to First Step to obtain whatever treatment may be deemed necessary for: \_\_\_\_\_.

**Name of Child**

**DOB**

Authorization includes my consent for the above named child to receive treatment by a physician in any hospital emergency department. I hereby give my permission for emergency medical treatment as outlined above.

The school will make every effort to provide a safe and supervised environment for each child. However there are certain risks of injury which are beyond the control of the school /staff and which the parents/guardian acknowledges. By signing below the parents/guardian of said child fully release and discharge First Step and its staff from the liability of such injuries to their child and to other such medical emergencies which may occur and are beyond the control of the school staff.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Known Medical Problems:** Include allergies and any pre existing medical problems. Please note that children with allergies, asthma or existing medical issues that require regular treatment will need the appropriate documentation for us to administer any medications (Asthma/allergy plan from the doctors office and accompanying medications (epi-pen, inhaler etc) in a clear zip lock bag labeled with your child's name. Please see parent handbook for more detailed information regarding medication at school.

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**Additional Information:** Please include any information that you would like us to know that might help us to better support your child in our program.

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**Please note that in accordance with Maine State Licensing requirements, we need a Child's Record form and a current copy of your child's immunizations before your child's start date in our program. It is important that you keep First Step up to date on any changes in regards to information on this form and continue to update immunization forms as necessary. We will up update these documents annually.**