Emergency and Identification Information **PKFLP** ☐ **STATE** ☐ **Care Control ID#:** ____________ Quarter ________ Year _____
(To be completed by parent or guardian with a ball point pen) **CAL POLY** ☐ **KIDS U** ☐
GEN. CHILD CARE ☐

I. **Family Information**: Child lives with both parents ☐ with mother ☐ with father ☐ with Legal guardian ☐

Child's name (Last, First, Middle): ________________________ Birth Date: ____________ Gender: ☐ F ☐ M

Child's address: ________________________ Phone: ____________

Language spoken at home: ☐ English ☐Spanish ☐ Other __________ Phone **# we should use to contact you**: ____________

Primary Contact ☐ **Secondary Contact** ☐

Parent/Guardian #1: ________________________ Cell Phone: ____________

Business Address: ________________________ Phone: ____________

Bronco I.D.: ____________ SS #: ____________ Email: ____________

Primary Contact ☐ **Secondary Contact** ☐

Parent/Guardian #2: ________________________ Cell Phone: ____________

Business Address: ________________________ Phone: ____________

Bronco I.D.: ____________ SS #: ____________ Email: ____________

Person Responsible for Child

Name: ________________________

Home Phone: ____________ **Preferred Phone # we should use to contact you**: ____________

II. **Names of persons authorized to be called in an emergency and to take your child from the facility (This child will not be allowed to leave with any other person without written authorization from parent or guardian.) Please prioritize order in which we should call.**

Name	**Telephone**	**Relationship**
1.)		
2.)		
3.)		
4.)		

III. **Physician to Be Called in an Emergency**

Name: ________________________ Telephone: ____________

Address: ________________________

IV. **Dentist**

Name: ________________________ Telephone: ____________

Address, City, State: ________________________

V. **Medi-Cal Number:** ____________ **Medical Insurance:** ____________

Insurance Number: ____________

VI. **Allergies, Other Medical Limitations or Special Instructions:** ________________________

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VII. **Permission for medical treatment and administration procedures varies among medical personnel and medical facilities, with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance. As the parent or authorized representative, I herby give consent to Cal Poly Children's Center to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D.) osteopath (D.O.) or Dentist (D.D.S.) for the care of my child,** ________________________**.**
(**Child's** Name)

This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the child named above.

____________ ____________ ____________
Date **(Print parent/Legal guardian name)** **(Parent/Legal guardian signature)**

Rev. 10/8/2009