



## CALICO CENTER FAMILY INFORMATION AND EMERGENCY MEDICAL AUTHORIZATION FORM

Please complete this form and return it to: Amy Lilenfield / Calico Center

DATE COMPLETED \_\_\_\_\_ BY WHOM: \_\_\_\_\_

CHILD	MOTHER	FATHER
NAME:	NAME:	NAME:
Birthdate:	Home Address (if different than child's):	Home Address (if different than child's):
Age Now:	Work Phone:	Work Phone:
Nicknames:	Cell Phone:	Cell Phone:
Address:	Home Phone:	Home Phone:
City/State/Zip:	Other phone numbers where parent may be reached during day:	Other phone numbers where parent may be reached during day:
Child lives with:	Employed by:	Employed by:

**EMERGENCY CONTACTS:** List three other close friends/relatives/neighbors who can be contacted in case of an emergency (and may pick up or receive the child at home) if you, the parent, cannot be reached:

Name:	Name:	Name:
Address:	Address:	Address:
City/State/Zip:	City/State/Zip:	City/State/Zip:
Phone:	Phone:	Phone:
Relationship to child:	Relationship to child:	Relationship to child:

People who may pick up child or receive child at home (must be at least 16 years old); please include parents/guardians:

Name:	Relationship to child:
Name:	Relationship to child:
Name:	Relationship to child:

**MEDICAL/PHYSICIAN INFORMATION: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while in attendance at Calico when parents cannot be reached.**

**DOCTOR OR DENTIST PREFERRED IN CASE OF AN EMERGENCY:**

Doctor or Clinic:	Dentist or Clinic:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Medical Specialist:	Local Hospital:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:

**List child's known allergies, medical conditions and/or diagnosis:** \_\_\_\_\_  
\_\_\_\_\_

**PARENTAL CONSENT: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. I understand that my child's record may also be released to the hospital staff and/or physician upon treatment. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART II. REFUSAL TO GRANT PERMISSION**

I DO NOT give consent for emergency medical treatment or permission to the program staff to arrange for transportation and have my child transported for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action to be taken: \_\_\_\_\_  
\_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CALICO CENTER MEDICAL STAFF TREATMENT AUTHORIZATION**

I grant permission for my child, \_\_\_\_\_, to be treated by a CALICO Center Nurse and/or the CALICO Center consulting physician in the event of an emergency, illness, or for prescribed health procedures approved by myself and my child's physician.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ROSTER AUTHORIZATION OR REFUSAL:**

Your child's name will be included in the class lists distributed for school events. A class roster of names, addresses and phone numbers will also be made available for parents who request them. This is not distributed except upon request. Do you wish for your name, address, phone number to be included in the class roster that parents may request?

Name:    \_\_\_ Yes   \_\_\_ No

Address:   \_\_\_ Yes   \_\_\_ No

Phone:    \_\_\_ Yes   \_\_\_ No

**PROCARE ELECTRONIC PARENT CLOCK IN/OUT:**

In order to electronically check your child in and out of Calico each day you will be provided a 4 digit Personal Identification Number (PIN). Please provide your 1<sup>st</sup> and 2<sup>nd</sup> choices below.

1<sup>st</sup> choice   \_\_\_ \_\_\_ \_\_\_ \_\_\_

2<sup>nd</sup> choice   \_\_\_ \_\_\_ \_\_\_ \_\_\_