CHILD INTAKE RECORD

ND DEPARTMENT OF HUMAN SERVICES
EARLY CHILDHOOD SERVICES
SFN 812 (4-2009)

Clear Fields

FOR USE DURING EMERGENCIES AND DISASTERS

Child's Name:			Date Child Enrolled:
Preferred or Nickname of Child:	Birth Date:		Age:
Name of Parents/Legal Guardians:	Telephone Number:		Cell Phone Number:
Address:	City:	State:	ZIP Code:
Place of Employment:			Employment Telephone Number:
Employment Address:	City:	State:	ZIP Code:

Does The Child Have Any food, medication or environmental allergies: ☐ Yes ☐ No

If Yes, List Allergies:	Describe Allergy Reaction:	Usual Treatment:

Please Check If Any Of The Following Conditions Exist:

☐ Asthma ☐ Heart Condition ☐ Hearing Impairment ☐ Behavioral Issues
☐ Diabetes ☐ Seizure Disorder ☐ Frequent Earaches ☐ Other Conditions (please specify): _____
☐ Vision Impairment

Please Explain All Checked Items:

Is The Child Under Current Medical Treatment? ☐ Yes ☐ No If yes, please list:

Are There Any Medications That The Child Takes Daily? ☐ Yes ☐ No If yes, please list:

Describe Any Limitation Your Child May Have For Participation In An Early Childhood Program:

EMERGENCY AUTHORIZATION/AUTHORIZATION TO RELEASE CHILD

In case of an emergency and parents cannot be reached, who should be contacted?

Name:		Relationship to Child:
Home Telephone Number:	Cell Phone Number:	Work Telephone Number:
Name:		Relationship to Child:
Home Telephone Number:	Cell Phone Number:	Work Telephone Number:
Family Physician:	Clinic:	Name of Insurance Company:

I hereby authorize the Early Childhood Program to secure emergency medical treatment for my child under the following conditions:

1. An emergency or unanticipated condition necessitates immediate action for the preservation of the life or health of the child, and
2. Reasonable attempts to contact me have failed.

Parent or Responsible Party Signature:	Date:	Parent or Responsible Party Signature:	Date: