

Nature Sprites EMERGENCY INFORMATION & AUTHORIZATION FOR TREATMENT & TRANSPORTATION

Child's Name _____ **Nickname** _____ **Date of Birth** _____
Last First

Home Address _____ **Home Phone** _____
Street City/State Zip

Parent/Guardian Name _____ **Cell Phone/Pager** _____
Last First
Employer / School _____

Employer/School Address _____ **Phone** _____ **Ext.** _____
Street City/State Zip

Parent/Guardian Name _____ **Cell Phone/Pager** _____
Last First
Employer / School _____

Employer/School Address _____ **Phone** _____ **Ext.** _____
Street City/State Zip

Alternate Emergency Contact:

(1) _____
Name Relationship Phone Number Cell Phone Pager

Address _____

(2) _____
Name Relationship Phone Number Cell Phone Pager

Address _____

Additional Person Authorized to Pick up Child:

(1) _____
Name Relationship Phone Number Cell Phone Pager

Address _____

(2) _____
Name Relationship Phone Number Cell Phone Pager

Address _____

Health Care Facility _____
Name Address (if known) Phone Number Pager

Allergies/Reactions _____

Chronic Illnesses/Special Needs _____

Medications _____
Insurance Information _____

Authorization for emergency medical care and transportation:

In the event of an emergency I hereby give my permission for child care staff to access emergency medical services for my child, including transport to the nearest health care facility, to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be made to locate me, and I accept the expense of care and transport.

Parent/Guardian Signature Date Parent/Guardian Signature Date

Child Care Facility _____
Name _____ Address _____ Phone _____ Cell Phone _____

CHILD ENROLLMENT RECORD NATURE SPRITES

Date of Enrollment _____

Child's Name

_____ **Nickname** _____

Home Address

Home Phone _____ **Sex** **M** **F** **Age** _____ **Date of Birth** _____

Family Members:

Mother or Guardian's Name

Address if different from child's

Zip _____ **Home Phone** _____ **Cell Phone** _____ **Email** _____

Name of employment
(mother/guardian) _____

Address of employment (mother/guardian) _____ **Work Phone** _____

Father or Guardian's Name

Address if different from child's

Zip _____ **Home Phone** _____ **Cell Phone** _____ **Email** _____

Name of employment
(father/guardian) _____

Address of employment (father/guardian) _____ **Work Phone** _____

Special instructions for reaching parent or guardian

EMERGENCY CONTACTS

1. Name _____ Home Phone _____

Address _____

Work Phone _____ Relationship to child _____

2. Name _____ Home Phone _____

Address _____

Work Phone _____ Relationship to child _____

CHILD PICK UP INFORMATION

Persons authorized to pick up your child
(Must show photo ID)

Name _____

Home Phone _____ Work Phone _____

Name _____

Home Phone _____ Work Phone _____

Name _____

Home Phone _____ Work Phone _____

Name, address and phone number of child's doctor

Name, address and phone of child's dentist

Hospital of Preference (Please check one)

Boulder Foothills Community Hospital
4747 Arapahoe Avenue
Boulder, CO
(720) 854-7010

Boulder Community Hospital Emergency Dept

**311 Mapleton Ave
Boulder, CO
303-440-2273**

Other: _____

Chronic Medical conditions

Does your child have a health care plan ? _____ If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized ? _____ Completed immunization records must be provided on or before the first day the child is in care.

Food Allergies

HEALTH HISTORY ALLERGIES

(Chronic or recurring) (Nature of Reaction)

Ear Infections _____ Hay Fever _____

Diabetes _____ Plant Poisoning _____

Heart disease/defect _____ Insect stings _____

Convulsion/seizures _____ Penicillin _____

Asthma _____ Other drugs _____

Nosebleeds _____ Animals _____

Measles _____ Food _____

Mumps _____ Other _____

Chicken Pox _____

Flu or Flu shot _____

Operations or serious injuries

(dates) _____

Is the child on any medications?

(Explain) _____

**If yes, please
describe _____**

Physical limitations _____ Describe if yes _____

Dietary limitations _____ Describe if yes _____

Vision _____ Hearing _____

Are there any activities that you prefer that your child NOT participate in?

If so please list:

Authorization for Emergency Medical Care

I hereby give my permission to _____ to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____.

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment.

Parent/Guardian signatures

_____ Date _____

_____ Date _____

Nature Sprites

Sunscreen and Insect Repellent Permission Form

I give permission for staff members of the Staff at Nature Sprites to apply sunscreen and insect repellent to my child: _____

OR

I have provided and labeled for my child the following brand of sunscreen/insect repellent:

Parent or Guardian _____

Signature _____ Date _____