

Date: _____

Great New Beginnings, Inc.

Parental Consent and Emergency Information

Emergency Data:

Child's Name: _____ D.O.B. ____/____/____

Address: _____

Father's Data:

Name: _____

Home Telephone: _____

Cell Phone: _____

Email: _____

Home Address: _____

Mother's Data:

Name: _____

Home Telephone: _____

Cell Phone: _____

Email: _____

Home Address: _____

Employer's Name/Address:

Work Phone/Ext. or Dept. _____

Hours of Employment: _____

Employer's Name/Address:

Work Phone/Ext. or Dept. _____

Hours of Employment: _____

Person to be contacted in an Emergency if Parents are not available:

Name: _____

Address: _____

City/State/Zip: _____

Home Telephone: _____

Work Telephone: _____

Relationship to Child: _____

Physician's Name: _____ Telephone: _____

Street Address/City/State/Zip: _____

Dentist's Name: _____ Telephone: _____

Street Address/City/State/Zip: _____

Health Insurance Company Name and Policy/Identification Number:

Allergies: _____

Physical/Developmental Disabilities (if so, IEP or 504 Plan is provided to Great New Beginnings):

1) _____ NAME _____ PHONE _____ 2) _____ NAME _____ PHONE _____ 3) _____ NAME _____ PHONE _____

Others who may pick up child:

(Please date next to any information that may be added, removed, or updated)

Name: _____

Home Telephone: _____

Address: _____

Work Telephone: _____

City/State/Zip: _____

Relationship to Child: _____

Name: _____

Home Telephone: _____

Address: _____

Work Telephone: _____

City/State/Zip: _____

Relationship to Child: _____

Name: _____

Home Telephone: _____

Address: _____

Work Telephone: _____

City/State/Zip: _____

Relationship to Child: _____

Name: _____

Home Telephone: _____

Address: _____

Work Telephone: _____

City/State/Zip: _____

Relationship to Child: _____

Name: _____

Home Telephone: _____

Address: _____

Work Telephone: _____

City/State/Zip: _____

Relationship to Child: _____

Written Consent Is Given For Items Below: (Parent signature required)

_____ Administration of Minor First Aid

_____ Emergency Medical Treatment

_____ Emergency Medical Transportation

_____ Administration of Prescription Medication (**Updated Form on File**)

_____ Administration of Non-Prescription Medications (**Updated Form on File**)

_____ Walking Excursions (off premises)

_____ Swimming (summer camp only)

_____ Homework Supervision

_____ Photographs (for both marketing and classroom activities)

_____ If a child is transported by the facility, are there any special instructions for care (example: motion sickness, seizures, etc.) during transportation? ___ Yes ___ No

If yes, please specify: _____

Parent Signature: _____ Date: ____/____/____