



## Emergency Information and Immunization Record Card

<b>Child's Name:</b>	<b>Date Enrolled:</b>	Updated:
<b>Home Address:</b>		<b>Date Disenrolled:</b>
<b>Home Phone:</b>	<b>Date of Birth:</b>	Sex: <input type="checkbox"/> male <input type="checkbox"/> female

<b>Mother or Guardian Name:</b>	<b>Home Address :</b>	<b>Home Phone:</b>
Cell Phone (optional):	<b>Business Address:</b>	<b>Business Phone:</b>

<b>Father or Guardian Name:</b>	<b>Home Address:</b>	<b>Home Phone:</b>
Cell Phone (optional):	<b>Business Address:</b>	<b>Business Phone:</b>

I authorize the following individuals to collect my child from the facility if I cannot be located:

<b>Name:</b>	<b>Address:</b>	<b>Phone:</b>
<b>Name:</b>	<b>Address:</b>	<b>Phone:</b>
<b>Name:</b>	<b>Address:</b>	<b>Phone:</b>
<b>Name:</b>	<b>Address:</b>	<b>Phone:</b>

The following individual(s) may NOT remove my child from the facility:

<b>Name(s):</b>
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Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

If Medical care is necessary, CALL:

<b>DOCTOR</b>	<b>Name:</b>	<b>Address:</b>	<b>Phone:</b>
<b>HOSPITAL</b>	<b>Name:</b>	<b>Address:</b>	<b>Phone:</b>

**I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.** It is understood by me that the expense of this service will be accepted by me.

In case of injury or sudden illness, I request that this individual be called first:
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Does your child have insurance coverage? ☐ No ☐ Yes Name of Insurance Company:

Telephone Authorization Code : \_\_\_\_\_ (optional)

## Immunization Information

One of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

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## Medical Information

Is child allergic to food or other substances? If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is child usually susceptible to infections and if so, what precautions need to be taken? If yes, list precautions:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is child subject to convulsions and what should be our procedure if one occurs? If yes, specify procedure:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? If yes, list precautions:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Additional comments:	
Other special instructions:	

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE:
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