Nebraska Department of Health and Human Services

CHILDREN'S RECORD

PARENTS: PLEASE FILL IN ALL BLANKS

Child's Name:____________________________________ Birthdate:____

Child's Name:____________________________________ Birthdate:____

Enrollment Date:_________________________________ Last Enrollment Date:______________________________

Parent or Guardian's Home Address and Employment Address:

MOTHER (or Guardian):
Name: ____ Employer:_________________________________

Address: ____ Address: ___________________________________

City________________ Phone: ____________________ City________________ Phone: ________________

FATHER (or Guardian):
Name:____ Employer:__________________________________

Address:____ Address: ___________________________________

City________________ Phone:____________________ City________________ Phone: ________________

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one besides parents, please write "NONE"):

Name:____ Name:____

Address:____ Address:____

City________________ Phone:____________________ City________________ Phone:____________________

Name:____ Name:____

Address:____ Address:____

City________________ Phone:____________________ City________________ Phone:____________________

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME IS REQUIRED)

Name:____ Name:____

Address:____ Address:____

City________________ Phone:____________________ City________________ Phone:____________________

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to______________________________
Caregiver

to contact Doctor____ .
Name of Physician

____ ____
Address City Phone

____ ____________________________
Signature of Parent/Guardian Date

Medication Competency Statement:

I, ____have determined
Parent/Guardian Name

KELLY'S KIDS STAFF
____competent to give or apply medication to my child(ren).
Provider/Director **(THIS MUST BE FILLED IN)**

____ _______________________________
Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

PLESE FILL IN ALL BLANKS: Write NONE if it does not apply.

Any health problem which caregiver should know: ____

Medication, if any:____

Allergies, if any:____

Special Concerns: (Glasses, Hearing Aid, Crutches) ____

Any Activity child(ren) should NOT engage in:____

Company providing health and/or accident insurance coverage: (Optional)_____________________________________

Shot Records:

All families must provide a copy of their child(ren)'s shot records prior to starting at Kelly's Kids. Please bring a copy or have your physician fax them.

Fax Number: (402) 477-0691

I certify that the above information is correct to the best of my knowledge.

____ __________________________________
Signature of Parent/Guardian Date