

**CHILD INFORMATION CARD**  
**State of Delaware**  
**Department of Education**

| <b>Child's Information</b>  |                      |   |                      |
|---|----------------------|---|----------------------|
| Child's name:   | Date of birth:       | Date of enrollment:   | Date of discharge:   |
| Child's address:  |                      | Hours and days child is scheduled to attend:  |                      |
| <b>Parent/Guardian Information (1)</b><br>Emergency Contact/Authorized to Pick-up Child |                      | <b>Parent/Guardian Information (2)</b><br>Emergency Contact/Authorized to Pick-up Child |                      |
| Name:   |                      | Name:   |                      |
| Address, if different from child's:   |                      | Address, if different from child's:   |                      |
| Home phone:   | Cell phone:          | Home phone:   | Cell phone:          |
| Work phone:   | Hours of employment: | Work phone:   | Hours of employment: |
| Employer name and address:  |                      | Employer name and address:  |                      |
| <b>Additional Emergency Contacts and People Authorized to Pick-up Child</b>             |                      |   |                      |
| Name:   | Address:             |   | Phone:               |
| Name:   | Address:             |   | Phone:               |
| Name:   | Address:             |   | Phone:               |

**Emergency Medical Care**

I, \_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

**Transportation**

I, \_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

| <b>Medical Information</b>                                 |  |
|--|--|
| Name of child's physician:                                 | Office phone:                                |
| Special medical information, medications, allergies, diet: | Health insurance identification information: |

*The above information is necessary for your child's protection and this facility is required to have it. Keep this information current.*