



Rochester Childfirst Network

SERVING CHILDREN SINCE 1857

STUDENT CONTACT & ALLERGY INFORMATION

For office use:

Rec'd by date: _____

Entered by date: _____

Child's Name: _____

Birthdate: _____

Adult/Guardian #1 Name: _____
 Relation: _____
 Home Address: _____

 City/State: _____ Zipcode: _____
 E-mail Address: _____
 Employer: _____
 Social Security #: XXXX-XX- _____
 Home Number: _____
 Cell phone Number: _____
 Work Number: _____

Adult/Guardian #2 Name: _____
 Relation: _____
 Home Address: _____

 City/State: _____ Zipcode: _____
 E-mail Address: _____
 Employer: _____
 Social Security #: XXXX-XX- _____
 Home Number: _____
 Cell phone Number: _____
 Work Number: _____

FAMILY STRUCTURE (Circle appropriate answers)

Parent marital status: Single Married Divorced Widowed

Do you have a custody arrangement? _____

Is there an order of protection? Yes No

Expiration date: _____ Against whom? _____

***If applicable, please provide the legal documentation.**

Other children in the family	Date of Birth	School/Daycare

Primary Care Physician's Name: _____ **Phone Number:** _____
Practice: _____

Check boxes below to indicate if your child has any special needs/services:

- None
- Early Intervention
- Speech/Language
- IEP (please provide a copy)
- Special Education
- Physical Therapy
- ISFP (please provide a copy)
- Occupational Therapy

Preferred hospital: _____ **Phone Number:** _____

Child's Name: _____ Birthdate: _____

ALLERGIES: Does your child have allergies? Yes No (If yes, please provide details)

MEDICAL / PHYSICAL CONDITIONS: (Please be specific) _____

MEDICATIONS:(List prescription/over the counter medications with dosage.)

If your child will be taking medications at RCN, please contact the main office for appropriate consent forms. **Medication cannot be dispensed without consent.** Ointments must be supplied by the parent/guardian in the original packaging, labeled with the child's first and last name, and written instructions regarding dosage & frequency of use.

Indications for medication and/or special instruction: _____

Possible side effects: _____

RCN has permission to apply the following ointments to my child named above:

- Sunscreen Vaseline Chapstick Antibacterial Ointment
 Calamine Lotion Hand Lotion Cortisone Diaper Cream (non-prescription)
 Other (please specify) _____

RCN Center Staff is authorized to apply the designated center sunscreen to my child when their personal sun screen is not available. Yes No

DIETARY PREFERENCES:

- No Pork No Beef No Beef Prefer Soy milk Prefer Almond milk Vegetarian
 Other (please specify): _____

EMERGENCY CONTACTS AND ESCORTS:

Name & Address	Relationship	Primary #:	Secondary #:	Lives with	Emergency Contact	Authorized to Pick Up
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Additional names, see additional paper.

Child's Name: _____ Birthdate: _____

CHILD'S DEMOGRAPHIC INFORMATION:

Rochester Childfirst Network relies on grant funding and governmental funding sources to offset some operational and program expenses. Most public and private funders require us to provide demographic information of the populations we serve as part of our application. By supplying us with the following information you are helping us to ensure we can continue to provide our services at the lowest rate possible.

I choose not to provide this information

Gender: Male Female

Ethnicity: Hispanic or Latino
 Not Hispanic or Latino

Religion (please specify):

Race:

American Indian or Alaska Native Asian
 Native Hawaiian or Other Pacific Islander White
 Black or African American

Preferred Language:

English Spanish Nepalese Other (please specify):

How did you heard about us? _____

AGREEMENT:

- I consent to emergency medical treatment for my child (i.e., Call 911). Yes No
- I consent for my child to take part in off RCN campus trips (i.e., library, park, and playground) away from the program under proper supervision. Yes No
- I understand the program may need additional permissions for situations such as transportation, medication, the release of information, and field trips. Yes No
- I provided information on my child's special needs to the program to assist in caring for my child.
 Yes No N/A
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation. Yes No
- I agree to review and update this information whenever a change occurs and at least once every year.
 Yes No
- I read/understood RCN's handbook. Yes No

AUDIO/VISUAL RELEASE:

- RCN has my permission to photograph or video my child for ONLY classroom purposes. Yes No
- RCN has my permission to film or photograph my child. The videos, films, or photographs may be used for training or advertisement purposes. I hereby waive the right to compensation for use of the above at any time. RCN may show or exhibit the videotapes, films, or photographs at any time without my prior knowledge or notification. Yes No

Parent/Legal Guardian Signature: _____

Date: _____