CHILD RECORD FORM

Today's Date: _____

Child's Date of Birth: _____ Date of Enrollment: _____

Child's Name: _____ Nickname: _____

Address: _____ Sex: _____

City/Zip: _____ Phone: _____

Mother's Name: _____

Home Address (if different from above): _____

Employer: _____ Occupation: _____

Work Address: _____

Work Phone: _____ Pager or Cell Phone: _____

Father's Name: _____

Home Address (if different from above): _____

Employer: _____ Occupation: _____

Work Address: _____

Work Phone: _____ Pager or Cell Phone: _____

Name of Siblings: _____ Age _____
_____ Age _____
_____ Age _____

Primary Email Address: _____

Please select which of the following types of information you would like to receive from PAC via email *(check all that apply)*

- ☐ PAC Monthly Newsletter – released the last week of each month highlighting upcoming PAC happenings
- ☐ Child Care Related News ONLY – including any special holiday hours or child care special events

MEDICAL INFORMATION

CURRENT COPY OF IMMUNIZATION (OR NOTARIZED WAIVER) IS REQUIRED

Physician: _____ Phone _____
Dentist: _____ Phone _____

Insurance Information:
Insurance Company: _____
Name of Subscriber: _____

PARENTS ARE RESPONSIBLE FOR ALL EMERGENCY MEDICAL TREATMENTS.

In case of emergency, contact: _____
Relationship to child: _____ Phone _____

AUTHORIZATION TO RELEASE

Other than the above parent/guardians, only the following person(s) may remove your child from care without previous notice. PHOTO ID WILL BE REQUIRED.

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____

If sudden illness or other serious medical emergency should occur and I cannot be reached, my signature below authorizes the person in charge to call my child's physician or dentist or take my child to the nearest emergency medical facility.

_____ _____

Signature of Parent or Guardian Date

MEDICAL INFORMATION

List any frequent illnesses and/or hospitalizations: (ear infections, strep throat, seizures, etc.)

List any known allergies: _____

What communicable diseases has your child had? (chicken pox, measles, mumps, etc)

Is your child currently taking medications? ☐Yes ☐No

If yes, what? _____ Why? _____

Does your child receive therapeutic services in developmental center or school? _____

Does your child receive therapeutic services in a developmental center or school? _____

If yes, please check which services:
☐ Occupational therapy ☐Physical therapy ☐Speech Therapy
☐Behavior therapy ☐Psychological/Counseling services

Mobility: (check any that apply)
☐Walks ☐Uses wheelchair ☐Wears adaptive shoes
☐Uses cane ☐Uses walker ☐Does not move self
☐Crawls

Would your child be able to evacuate the building without assistance? ☐Yes ☐No

Communication: (check any that apply)
☐Wears glasses ☐Wears hearing aides ☐Lip reads
☐Uses light board or other adaptive device ☐Uses sign language or hand signals

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EATING HABITS

If your child is an infant, check which nourishment: ☐Breast ☐Formula ☐Combination

Any history of colic? ☐Yes ☐No Time of Day? _____

Child's favorite foods: _____ Food dislikes? _____

How has your child been fed? ☐ Held in lap ☐Highchair ☐At table ☐ Other

Does your child east unassisted using: ☐Fingers ☐Fork ☐Spoon ☐Knife
Does your child drink from: ☐ Bottle ☐Sipper Cup ☐Regular Cup

Does your child require the use of a dropper, weighted cup or other adaptive equipment to self-feed?
☐Yes ☐No

Eating habits you are concerned with? _____
_____

RESTROOM HABITS

Are bowl movements regular? ☐Yes ☐No How many per day? _____
Times: _____

Has toilet training been attempted? ☐Yes ☐No

Please check what is used at home:
☐Diapers ☐Pull-ups ☐Potty Chair ☐ Special toilet seat ☐Regular toilet seat

Does your child have frequent diaper rashes? ☐Yes ☐No

What works to treat the rashes? ☐Yes ☐No

Can your child be relied upon to indicate the need to use the restroom? ☐Yes ☐No

How does your child communicate this? _____

My child does not indicate the need to use the restroom and should be taken to the toilet every _____ and should not be left, attended, on the toilet for _____minutes.

How often does your child have accidents? _____

Any special comments or concerns? _____

SLEEPING HABITS

At what time does your child go to bed and night? _____

What time does he/she awaken in the morning? _____

Does he/she wake frequently in the night? ☐Yes ☐No Have nightmares? ☐Yes ☐No

Does your child have his/her own bed? ☐Yes ☐No Require a nightlight? ☐☐Yes ☐No

He/she sleeps in own bed: ☐Whole night ☐Part night

Does he/she: ☐Walk ☐Talk ☐Cry during the night?

Does he/she take a nap? ☐Yes ☐No From _____ to _____

How does your child fall asleep?
☐Rocking ☐Holding ☐On their own ☐Story ☐Music

Other: _____

Any other comments or concerns? _____

In what particular way can we help your child? _____
_____

Authorization of Medical Treatment

AUTHORIZED ADULTS

In the event of an emergency, please indicate your name and phone number where you and authorized person can be reached.

Father's name _____ Phone _____

Mother's name __ _____ Phone _____

Another authorized person _____

Address _____

I, _____ hereby give permission to _____

To obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is _____ and date of birth is _____ should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians/dentists may be taken. I further consent to transportation of the above named child to the nearest or most appropriated medical facility.

The medical insurance company that covers the above named child is:

Company Name _____

Company Address _____

Name of Policy Holder _____ Policy Number _____

I authorize the hospital and attending physicians to submit claims to the above named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____

Consent for Child Care Program Activities

Name of Facility: Pinedale Aquatic Center Child Care

Address of Facility: 535 N. Tyler Ave., Pinedale, WY 82941

Name of Child: _____

Please answer the following question:

Do we have your permission to take your child to the PAC gymnasium to play? YES:___ NO:___

Emergency Consent:

In the event of an emergency, I hereby give consent for my child (named above) to be transported, whether walking or riding, by the Pinedale Aquatic Center Child Care.

Parent/Guardian Signature: _____ Date: _____

**In order to meet state requirements, monthly fire drills must be conducted. During our drills, we will evacuate the building with the children and go to the far side of the parking lot. We will not cross the street during our drills but in the event of a true emergency evacuation, we will meet at the Lutheran Church directly across the street from PAC.*

EVACUATION PROCEDURE

- In the event of an emergency that requires evacuation of the building, the posted evacuation route will be followed and the PAC Emergency Action Plan shall take effect.
- A staff member will escort all children out of the building, taking with them the sign-in log, emergency contact information, parent contact information, and the "go" bag. A front desk employee will come to the room to assist with the evacuation.
- Parents are not to come to the child care room to get their child and if a parent does, they will be asked to assist the staff member in escorting the children out of the building. Under no circumstances shall a parent leave with their child during an evacuation until the staff and children all reach the designated meeting location (Lutheran Church across the street) and the parent communicates with the staff member.
- In the case of an emergency situation that requires securing the premises, child care staff will follow PAC protocol as outlined in the PAC emergency action plan. The bathroom of the child care room is designed to serve as a safety zone in the event a barricaded area is needed. Child care staff's first priority is to provide for their own safety and the children in the room.

Parent/Guardian Signature: _____ Date: _____

Pinedale Aquatic Center
535 N. Tyler Pinedale WY 82941 (307) 367-2832 www.pinedaleaquatic.com

Permission to Photograph

Pinedale Aquatic Center has permission to photograph my child_____.
(Child's name)

These photographs may be used for the following purposes:

PAC Activity Guide

PAC Facebook

PAC Website

Wall murals

Scrapbooks

For instructional purposes

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Parent or Guardian signature: _____

Date: _____