

CHILD INFORMATION RECORD

Date of Admission					
Name of Child (Last, First, Middle Initial)			Address (Number & Street, Building/Apartment Number)		
Child's Date of Birth	Home Phone Number ()		City	State	Zip Code
Father/Legal Guardian's Name			Mother/Legal Guardian's Name		
Home Address: (If not child's address)			Home Address: (If not child's address)		
City	State	Zip Code	City	State	Zip Code
Employer/School Name			Employer/School Name		
Address (Employer/School)			Address (Employer/School)		
City	State	Zip Code	City	State	Zip Code
Employer/School Phone:	Hours of Employment/School		Employer/School Phone:	Hours of Employment/School	
Name of Local Person to be Notified in an Emergency when parent is not available			Local Address and Phone Number of Emergency Person		
Home Phone	Work Phone		City	State	Zip Code
Name(s) of Person other than Parent or Legal Guardian to Whom Child may be released					

BRS-3731 (Rev. 8-16) Previous edition may be used.

I give permission to _____, licensed by the Department of Consumer and (Child Care Provider) Industry Services to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.		
Signature of Parent or Guardian	Date Signed	AUTHORITY: Act 116 of P.A. 1973. COMPLETION: Required. PENALTY: Rule Violation Citation.
Space for Notarization (If Required by Local Medical Facility)		
Name and Address of Child's Physician or Health Clinic		Phone Number ()
Hospital Preferred for Emergency Treatment	Health Insurance Policy Name and Number	
Allergies, If Any	Date of Last Tetanus Shot	
Field Trip: I hereby give my permission to: _____ for my child to be transported in a vehicle and/or participate in field trips. Provider's Name		
Signature of Parent or Guardian	Date Signed	
The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an DCIS office in your county.		

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