



MEDICAL AND AUTHORIZATION INFORMATION

Name of child: _____ Birthdate: _____
Mother's Name _____ Cell # _____ Email: _____
Father's Name _____ Cell # _____ Email: _____
Address _____ City _____ Zip _____
Home Phone _____

General Information:

Below, please list the names of the persons authorized to pick up your child. Your child will not be released to others without your permission. You may authorize an individual for a particular day by placing their name on the daily sign-in sheet. Please advise designated persons to have proper identification available. If an emergency arises you may call Chapel Hill Church (651) 681-1658 and give verbal permission to release your child to an individual.

Authorization for release:

Mother _____ Father _____
Others:
Name _____ Phone _____
Name _____ Phone _____
Persons available locally to be called in an emergency:
Name: _____ Phone _____
Name: _____ Phone _____

Medical Authorization and Information:

In case of an accident or illness, if I (we), the parent(s) or guardian(s), are not available, my (our) child should receive medical treatment by: Children's Praise N' Rainbows staff, by his/her doctor, or by personnel of a hospital emergency room.

Child's Doctor: _____ Clinic: _____
Clinic Address: _____ Phone: _____
Hospital: _____
Any Food or Drug Allergies: _____

My child is current on his/her immunizations: Yes or No (please circle one)

Signature _____ Date: _____