



Mandala Children's House

5038 Hyland Ave • San Jose, CA 95127
Tel (408) 251-8633 • Fax (408) 251-8697

2007-2008

CHILD IDENTIFICATION AND EMERGENCY INFORMATION FORM

| | | |
|----------------------------|------------------------------------|--|
| Child's Name _____ | Birthdate _____ | Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| (First) _____ (Last) _____ | | |
| Home Address _____ | (City) _____ | (Zip Code) _____ |
| (Street) _____ | | |
| Home Phone _____ | Child's Home Language _____ | Ethnicity _____ |

Mother's/Guardian's Name _____ **Cell Phone/Pager** _____

Address _____ **Home Phone** _____

(if different than above)

Employer _____ **Work Hours** _____ **Work Phone** _____

Employer Address _____ **Occupation** _____

Driver's License # _____ **E-Mail** _____

Father's/Guardian's Name _____ **Cell Phone/Pager** _____

Address _____ **Home Phone** _____

(if different than above)

Employer _____ **Work Hours** _____ **Work Phone** _____

Employer Address _____ **Occupation** _____

Driver's License # _____ **E-Mail** _____

Parents are (✓) Married Single Partnered Separated Divorced Deceased Out of Home Other _____

Person/s Legally Responsible for Child _____ **Relationship** _____

Address _____

Persons authorized to take child from the facility:

| Name | Telephone | Relationship |
|------|-----------|--------------|
| | | |
| | | |
| | | |

Important information concerning your child's safety (i.e.: allergies, medical concerns, custody, restraining orders):

Class (✓) Early Preschool Preschool **Starting Date** _____ **Termination Date** _____

T/Th M/W/F AM PM

(Please complete back of form →)

EMERGENCY MEDICAL RELEASE FORM

Medical Release and Consent

In the event that my child becomes ill or sustains an injury while in the care of Mandala Children's House, I give my permission to those in charge to take whatever steps necessary to obtain medical care for my child. If it is not possible to reach the doctor or dentist named below, or to receive my instruction for my child's care, I give my consent to any licensed physician and/or surgeon to whom my child is taken for treatment to administer drugs or medications and perform such surgical procedures as he/she shall think the emergency requires for the relief of pain and to preserve life and health. I understand and agree that I am financially responsible for any care so procured.

Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Medical Insurance Plan _____ Group # _____ ID # _____

Dental Insurance Plan _____ Group# _____ ID# _____

My child, _____, **does/does not have allergies to drugs or medications.**

List allergies to drugs or medications _____

Health problems _____

Special Instructions:

Additional persons who may be called in an emergency and to whom my child may be released:

| Name | Address | Telephone | Relationship |
|------|---------|-----------|--------------|
| | | | |
| | | | |
| | | | |

Signature of Parent _____ **Date** _____

