Print Form

Parkside Child Development Center Updated Information Form

Child's Information:

Name: _____ ☐ Male ☐ Female DOB:_____
Child resides with:_____
Special medical conditions (allergies, etc…)
_____
_____

Family Information:

Mother / Guardian Name: _____
Address_____
Street City State Zip
SS #: _____-___-_____ Email: _____
Phone Numbers: _____Home _____Cell _____Work
Employer Name: _____
Employer Address: _____

Father / Guardian Name: _____
Address_____
Street City State Zip
SS #: _____-___-_____ Email: _____
Phone Numbers: _____Home _____Cell _____Work
Employer Name: _____
Employer Address: _____

Local Emergency Contacts – Not mother or father - You must list two

1. Name: _____ Phone:_____ Home Cell Work (*circle one*)
   Phone:_____ Home Cell Work (*circle one*) Relation to Child:_____
2. Name: _____ Phone:_____ Home Cell Work (*circle one*)
   Phone:_____ Home Cell Work (*circle one*) Relation to Child:_____

Others Authorized to pick up your child *(other than emergency contacts)*

Name: _____ Phone:_____ Home Cell Work (*circle one*)
Phone:_____ Home Cell Work (*circle one*) Relation to Child:_____

Signed:_____ **Date:**_____

Physician's Name:_____ **Phone:**_____
Preferred Hospital: _____ **Phone:**_____

Along with this completed form, please bring an updated immunization record for your child! We recommend that you bring us an updated record EACH TIME your child receives an immunization!