# STUDENT CONTACT & ALLERGY INFORMATION

**Rochester Childfirst Network**
SERVING CHILDREN SINCE 1857

**For office use:**
Rec'd by date: _____
Entered by date:_____

Child's Name: _____  Birthdate: _____

Adult/Guardian #1 Name:_____
Relation:_____
Home Address: _____
_____
City/State: _____  Zipcode:_____
E-mail Address: _____
Employer:_____
Social Security #: XXXX-XX- _____
Home Number: _____
Cell phone Number: _____
Work Number: _____

Adult/Guardian #2 Name:_____
Relation:_____
Home Address: _____
_____
City/State: _____  Zipcode:_____
E-mail Address: _____
Employer: _____
Social Security #: XXXX-XX- _____
Home Number: _____
Cell phone Number: _____
Work Number: _____

## FAMILY STRUCTURE  (Circle appropiate answers)

Parent marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Do you have a custody arrangement? _____
Is there an order of protection?  ☐ Yes ☐ No
Expiration date:_____  Against whom?_____

*If applicable, please provide the legal documentation.*

| Other children in the family | Date of Birth | School/Daycare |
|---|---|---|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Primary Care Physician's Name:**_____  **Phone Number:** _____
**Practice:**_____
Check boxes below to indicate if your child has any special needs/services:

☐ None
☐ IEP (please provide a copy)
☐ ISFP (please provide a copy)

☐ Early Intervention
☐ Special Education
☐ Occupational Therapy

☐ Speech/Language
☐ Physical Therapy

**Preferred hospital:**_____  **Phone Number:** _____

Child's Name: _____  Birthdate: _____

**ALLERGIES:** Does your child have allergies?  ☐ Yes ☐ No  (If yes, please provide details)

_____

**MEDICAL / PHYSICAL CONDITIONS:**  (Please be specific) _____

_____

**MEDICATIONS:** (List prescription/over the counter medications with dosage.)

_____

If your child will be taking medications at RCN, please contact the main office for appropriate consent forms. <u>Medication cannot be dispensed without consent.</u> Ointments must be supplied by the parent/guardian in the original packaging, labeled with the child's first and last name, and written instructions regarding dosage & frequency of use.

**Indications for medication and/or special instruction:** _____

_____

_____

**Possible side effects:** _____

_____

---

**RCN has permission to apply the following ointments to my child named above:**

☐ Sunscreen  ☐ Vaseline  ☐ Chapstick  ☐ Antibacterial Ointment
☐ Calamine Lotion  ☐ Hand Lotion  ☐ Cortisone  ☐ Diaper Cream (non-prescription)
☐ Other (please specify) _____

RCN Center Staff is authorized to apply the designated center sunscreen to my child when their personal sun screen is not available. ☐ Yes ☐ No

---

**DIETARY PREFERENCES:**

☐ No Pork  ☐ No Beef  ☐ No Beef  ☐ Prefer Soy milk  ☐ Prefer Almond milk  ☐ Vegeterian
☐ Other (please specify): _____

---

**EMERGENCY CONTACTS AND ESCORTS:**

| Name & Address | Relationship | Primary #: | Secondary #: | Lives with | Emergency Contact | Authorized to Pick Up |
|---|---|---|---|---|---|---|
|  |  |  |  | ☐ | ☐ | ☐ |
|  |  |  |  | ☐ | ☐ | ☐ |
|  |  |  |  | ☐ | ☐ | ☐ |
|  |  |  |  | ☐ | ☐ | ☐ |

*Additional names, see additional paper.

Child's Name: _____ Birthdate: _____

## CHILD'S DEMOGRAPHIC INFORMATION:

Rochester Childfirst Network relies on grant funding and governmental funding sources to offset some operational and program expenses. Most public and private funders require us to provide demographic information of the populations we serve as part of our application. By supplying us with the following information you are helping us to ensure we can continue to provide our services at the lowest rate possible.

☐ I choose not to provide this information

**Gender:** ☐ Male  ☐ Female

**Ethnicity:** ☐ Hispanic or Latino
☐ Not Hispanic or Latino

**Religion (please specify):**
_____

**Race:**
☐ American Indian or Alaska Native   ☐ Asian
☐ Native Hawaiian or Other Pacific Islander   ☐ White
☐ Black or African American

**Preferred Language:**
☐ English  ☐ Spanish  ☐ Nepalese  ☐ Other (please specify):
_____

**How did you heard about us?** _____

## AGREEMENT:

- I consent to emergency medical treatment for my child (i.e., Call 911). ☐ Yes ☐ No
- I consent for my child to take part in off RCN campus trips (i.e., library, park, and playground) away from the program under proper supervision. ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, the release of information, and field trips. ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child.
  ☐ Yes ☐ No ☐ N/A
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation. ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year.
  ☐ Yes ☐ No
- I read/understood RCN's handbook. ☐ Yes ☐ No

## AUDIO/VISUAL RELEASE:

- RCN has my permission to photograph or video my child for ONLY classroom purposes. ☐ Yes ☐ No

- RCN has my permission to film or photograph my child. The videos, films, or photographs may be used for training or advertisement purposes. I hereby waive the right to compensation for use of the above at any time. RCN may show or exhibit the videotapes, films, or photographs at any time without my prior knowledge or notification. ☐ Yes ☐ No

**Parent/Legal Guardian Signature:** _____

**Date:** _____