

# Child Information Record

(Please Print legibly)

Date of Admission:

08/15/2009

Date of Discharge:

08/16/2009

Allergies:

Name of Child:

Child's Date of Birth (MM/DD/YYYY):

Address:

City:

State:

Country:

Zip:

Home Phone:

Cell phone:

Mother's name:

Father's Name:

Name(s) of Person other than Parent or Legal Guardian to whom child may be released:

Name of Child's Physician or Health Clinic:

Physician's or Health Clinic's Phone Number:

Address of Child's Physician or Health Clinic:

Name of Health Insurance Carrier:

Policy #:

Name of policy holder:

Hospital Preferred for Emergency Treatment:

Date of Last DTaP (Diphtheria, tetanus, pretussis) Shot:

Special Needs:

Special Instructions:

I give permission to Children's Hospital and Medical Center licensed by the Department of Human 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: \_\_\_\_\_