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| STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY | CALIFORNIA DEPARTMENT OF SOCIAL SERVICESCOMMUNITY CARE LICENSING DIVISION  |

# IDENTIFICATION AND EMERGENCY INFORMATIONCHILD CARE CENTERS/FAMILY CARE HOMES*To Be Completed by Parent or Authorized Representative: PLEASE WRITE LEGIBLY IN BLUE OR BLACK INK.*

**FY 2019-2020**

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| CHILD’S NAME LAST MIDDLE FIRST | SEX | BIRTHDATE (MM-DD-YYYY) |
| ADDRESS NUMBER STREET CITY STATE ZIP |
| PARENT/LEGAL GUARDIAN #1 NAME LAST FIRST | PHONE 1 (CIRCLE 1) CELL HOME WORK**( )**  - |
| ADDRESS **(IF DIFFERENT FROM CHILD’S)** NUMBER STREET CITY STATE ZIP | PHONE 2 (CIRCLE 1) CELL HOME WORK**( )**  - |
| PARENT/LEGAL GUARDIAN #2 NAME LAST FIRST | PHONE 1 (CIRCLE 1) CELL HOME WORK**( )**  - |
| ADDRESS **(IF DIFFERENT FROM CHILD’S)** NUMBER STREET CITY STATE ZIP | PHONE 2 (CIRCLE 1) CELL HOME WORK**( )**  - |
| CHILD RESIDES WITH (CHECK 1)🞎 BOTH PARENTS/LEGAL GUARDIANS 🞎 PARENT/LEGAL GUARDIAN #1 🞎 PARENT/LEGAL GUARDIAN #2 🞎 OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| PERSONS AUTHORIZED TO DROP OFF AND TAKE CHILD FROM THE FACILITY(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE)**(AUTHORIZED PERSON’S NAME MUST BE WRITTEN EXACTLY AS IT APPEARS ON THEIR PICTURE ID)** |
| **NAME** | **PHONE NUMBER** | **RELATIONSHIP TO CHILD** | **AUTHORIZATION (CHECK 1)** |
| **Besides yourselves (parents), indicate****by #1 below the FIRST PERSON you want us****to contact in an emergency** | **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** | **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** | **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** |
| **#1** | (CIRCLE 1) CELL HOME WORK**( )**  - |  | 🞎 DROP OFF AND PICK UP ONLY🞎 EMERGENCY ONLY 🞎 BOTH  |
|  | (CIRCLE 1) CELL HOME WORK**( )** - |  | 🞎 DROP OFF AND PICK UP ONLY🞎 EMERGENCY ONLY 🞎 BOTH  |
|  | (CIRCLE 1) CELL HOME WORK**( )** - |  | 🞎 DROP OFF AND PICK UP ONLY🞎 EMERGENCY ONLY 🞎 BOTH  |
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|  | (CIRCLE 1) CELL HOME WORK**( )** - |  | 🞎 DROP OFF AND PICK UP ONLY🞎 EMERGENCY ONLY 🞎 BOTH  |
|  | (CIRCLE 1) CELL HOME WORK**( )** - |  | 🞎 DROP OFF AND PICK UP ONLY🞎 EMERGENCY ONLY 🞎 BOTH  |
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| **PHYSICIAN AND DENTIST INFORMATION** |
| PHYSICIAN NAME  | PHONE NUMBER**( )**  - |
| DENTIST NAME  | PHONE NUMBER **( )**  - |
| **SIGNATURE OF PARENT / LEGAL GUARDIAN / AUTHORIZED REPRESENTATIVE****x** | **DATE**  (MM-DD-YYYY) |
|  |
| **TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE** |
| DATE OF ADMISSION  | DATE LEFT  |