Vital Information Card 2019-2020

Please fill out form completely

Child's Full Name: ___________________________________ D/O/B: ________________

Address/City/State/Zip: ____

Teacher: _______________________ Grade: ________________

Parent Name/Guardian: ________________________ Cell Phone: ________________________

Home Address/City/State/Zip (if different):____

Email: ____

Employer: ____________________________________ Work Phone: ________________________

Address/City/State/Zip: ____

Parent Name/Guardian: ________________________ Cell Phone: ________________________

Home Address/City/State/Zip (if different):____

Email: ____

Employer: ____________________________________ Work Phone: ________________________

Address/City/State/Zip: ____

Emergency Contacts

(Other than parent/guardian)

Name: _____________________ Cell Phone: _________________ Alt Phone: _____________________
Address/City/State/Zip: __________________________________ Relationship to child: _____________
Name: _____________________ Cell Phone: _________________ Alt Phone: _____________________
Address/City/State/Zip: __________________________________ Relationship to child: _____________

Additional Persons Authorized to Pick up

Name: _____________________ Cell Phone: _________________ Alt Phone: _____________________
Address/City/State/Zip: __________________________________ Relationship to child: _____________
Name: _____________________ Cell Phone: _________________ Alt Phone: _____________________
Address/City/State/Zip: __________________________________ Relationship to child: _____________
Name: _____________________ Cell Phone: _________________ Alt Phone: _____________________
Address/City/State/Zip: __________________________________ Relationship to child: _____________

Not Permitted to Pick-Up

Name: _________________________
Court Oder? Yes or No

Name: _________________________
Court Order? Yes or No

Health and Medical

If you answer yes to any of the following, please contact the Clinic Aide prior to August 19th. Appropriate forms will be given to you that will need to be signed by parent(S), physician and the Clinic Aide. Without a complete Health Care Plan, your child will not be able to start on the first day of school.

Does your child have any allergies? Yes or No
Please List All (including **food allergies**):
____

Does your child have any form of asthma? Yes or No   Does your child need an inhaler? Yes or No

Does your child take any medication, prescription or over-the-counter, on a regular basis? Yes or No
Please Explain:

Does your child have any other health conditions that may require special attention?   Yes or No
Please Explain: ____

<u>Please write N/A on the following below and do not leave blank:</u>

Pediatrician: _________________Phone:___________________ Address: ________________________

Dentist: ____________________Phone:____________________ Address: ________________________

Hospital: ____________________Phone:____________________ Address: _______________________

Authorization For Emergency Medical Care And Transportation

In the event of an emergency I hereby give my permission for Mountain Phoenix staff to access emergency medical services for my child, including transport to the nearest healthcare facility, to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be made to locate me, and I accept the expense of care and transport.

I certify that the information I have provided is true to the best of my knowledge. If any of the information changes I will notify the Licensing Director Immediately.

Please Check: Yes____ or No ____

Signature: ____   **Date: _________________**
(Parent/Guardian)