

**Bloomfield Extension Program  
Child Information Form**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ Desired Start Date in Program \_\_\_\_\_  
\_\_\_\_\_ Schedule (circle) AM PM AM/PM  
Home Phone \_\_\_\_\_ Days of Attendance \_\_\_\_\_  
School Child Registered At \_\_\_\_\_  
Grade your child will be entering \_\_\_\_\_

Is there documentation of a physical exam and immunization records on file at the child's school?  
 Yes  No

List any special limitations or concerns your child may have, including dietary restrictions, allergies, chronic health conditions, etc. \_\_\_\_\_  
\_\_\_\_\_

Child's identifying information and/or current picture (if available):

Sex \_\_\_\_\_ Height \_\_\_\_\_ Hair Color \_\_\_\_\_  
Weight \_\_\_\_\_ Eye Color \_\_\_\_\_  
Primary Language \_\_\_\_\_ Identifying Marks \_\_\_\_\_

**Primary Caregiver Information (also authorized for an emergency and pick-up)**

Parent/Guardian _____	Parent/Guardian _____
Relation to Child _____	Relation to Child _____
Home Address _____	Home Address _____
_____	_____
Home Phone _____	Home Phone _____
Business Name _____	Business Name _____
Business Address _____	Business Address _____
Business Phone _____	Business Phone _____
Hours at Work _____	Hours at Work _____
Cell Phone _____	Cell Phone _____

E-mail \_\_\_\_\_ (parent financial statements are distributed via e-mail)

Please list any special interests your child may have: \_\_\_\_\_  
\_\_\_\_\_

Is there any other information you would like us to know about your child? \_\_\_\_\_  
\_\_\_\_\_

**Handbook**

I, \_\_\_\_\_, have read **ALL** the Bloomfield Extension program policies and weekly payment arrangements and agree to follow them.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

## Bloomfield Extension Program Authorization & Consent Form

The following authorizations are necessary for the staff to act in your child's best interest at all times. Please complete and sign for each child. All authorizations must be updated annually.

Child's Name \_\_\_\_\_

### Physician & Insurance Information

Doctor's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

### Emergency Contact Information and Pick-Up Authorization

In case of *emergency contact*, please provide the names of individuals who may be called and are authorized to pick up your child if we cannot reach a parent. These individuals should be available and prepared to act on your behalf. These individuals are also authorized to pick-up your child in your absence. *Pick-up authorizations* are individuals who may pick up your child from the Extension Program. If these instructions should change, I will let the Program Director know by advance written notice.

Please indicate if the person is an emergency contact or pick-up authorization.

Name	Relationship	Telephone	Emer. Contact	Pick-Up Auth

Please note any special instructions or names of persons who are never authorized to remove your child from the Extension program. \_\_\_\_\_

### Emergency Care:

Extension staff receive first aid training and designated staff are trained in CPR for children and adults. Minor accidents such as cuts and scrapes will be treated with soap and water; bumps and bruises will be treated with ice. In the case of a more serious accidental injury, we will make an immediate attempt to contact a parent. If we cannot reach a parent or a designated emergency contact, we will call an ambulance and your child's physician. A staff member will accompany your child in the ambulance to the hospital you indicate below. You will be expected to assume responsibility for any resultant expense.

I consent for the Extension staff to administer first aid treatment to my child.

I consent for the staff to take my child to \_\_\_\_\_ Hospital and authorize treatment by the Physician on call.

I  authorize /  do not authorize Bloomfield Extension to use and reproduce photographs of my child and to circulate the same for advertising and publicity purposes of every description.

In order to plan for your child, if your child has an IEP (Individualized Education Program) and receives Special Education Services, are you willing to share the IEP with the Extension Program? please circle **YES** **NO**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date