

AUTHORIZATIONS FOR RELEASE / PICK-UP

- **Do you wish to authorize any other person to pick your child up at child care at ANY TIME WITHOUT NOTIFICATION?** YES _____ NO _____

People listed below will be able to pick up my child **WITHOUT NOTIFICATION:**
(**ID must be shown when picking up child**)

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

Name : _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

I hereby authorize Markman Children's Programs, Inc. or my Markman Family Child Care Provider to release my child to the following persons (other than myself). I understand **I MUST NOTIFY** Markman, and I may use **ONLY** the persons listed below: (**ID must be shown when picking up child**)

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

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- **Please contact the following person(s) if I cannot be reached in an EMERGENCY:**

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____

X _____
Parent/Guardian Signature

X _____
Date

HEALTH

CHILD'S DOCTOR: _____ PHONE: _____

ADDRESS: _____

CHILD'S DENTIST: _____ PHONE: _____

ADDRESS: _____

PHYSICAL CHARACTERISTICS:

HAIR COLOR: _____ HEIGHT: _____ WEIGHT: _____

EYE COLOR: _____ ETHNICITY(RACE): _____

IDENTIFYING MARKS: _____

Has your child had any serious illnesses or hospitalizations? Please describe. _____

Does your child have any allergies (asthma, hay fever, insect bites, medicines, or food)? _____

Are any medications given regularly? _____

How frequently does your child have the following symptoms:

	OFTEN	SOMETIME	RARELY	NEVER
Nosebleeds				
Earaches/Ear infections				
Stomachaches				
Diarrhea				
Constipation				
Bronchitis				
Tonsillitis/Strep throat				
Hay fever				
Colds				
Fevers				
Vomiting				
Cold Sores				

Has your child had a vision test? When?

Has your child had a hearing test? When?

Has your child had a sickle cell screening? When?

Any remarks concerning the above?

PERMISSIONS

I understand that every effort will be made to contact me in the event of an **EMERGENCY REQUIRING MEDICAL ATTENTION** for my child_____. However, if I cannot be reached, I hereby authorize Markman Children's Programs, Inc. or my Markman family provider to transport my child to Sturdy Memorial Hospital and to secure for my child the necessary medical treatment. I understand the teachers and providers are trained in the basics of First Aid and CPR and I authorize them to give my child first aid when appropriate.

Parent/Guardian Signature

Date

ADDITIONAL PERMISSIONS

Please check the boxes below that apply and sign and date at bottom:

- I give permission for Markman Children's Programs to apply Neosporin to treat minor injuries. My child is not allergic to these products.
- When there is a question about my child's medical condition, I give permission for Markman Child's Programs to contact my child's pediatrician or medical staff.
- I give permission for Markman Children's Programs, Inc. to transport my child by car or bus if necessary, under supervision.

I give permission to take/display pictures of my child for the following:

- Classroom/Center display
- Markman Chronicle (Agency Newsletter)
- Publication (Newspaper, Local Publications)
- Website

Parent/Guardian Signature

Date

FIELD TRIP PERMISSIONS

I give permission for Markman Children's Programs, Inc. to take my child on walking field trips to the following locations:

- City resources such as the Fire Station or Police Station if child is at 95 Pine Street
- The Attleboro duck pond on North Main Street if child is at 505 North Main Street

I also understand children will be supervised at all time by Agency Teachers, Staff or Volunteers.

I understand children will be transported by agency cars on any field trip requiring transportation.

I understand I will receive advance notice for any field trips **other than** those specified above. I will receive a permission slip to sign for each field trip that requires transportation by agency cars.

Parent/Guardian Signature

Date

SCHEDULE

I will need care on:

Monday _____ to _____

Tuesday _____ to _____

Wednesday _____ to _____

Thursday _____ to _____

Friday _____ to _____

I understand that the program fees must be paid Friday for the following week my child attends.

My fee is \$ _____ per week.

Parent/Guardian Signature

Date