DSCYF
Department of Services for Children, Youth & Their Families

TEMPORARY CHILD INFORMATION CARD
State of Delaware
Department of Services for Children, Youth, and Their Families

Child's Information			
Child's name:	Date of birth:	Date of enrollment:	Date of discharge:
Child's address:		Hours and days child is scheduled to attend:	
Parent/Guardian Information (1) Emergency Contact/Authorized to Pick-up Child		**Parent/Guardian Information (2)** Emergency Contact/Authorized to Pick-up Child	
Name:		Name:	
Address, if different from child's:		Address, if different from child's:	
Home phone:	Cell phone:	Home phone:	Cell phone:
Work phone:	Hours of employment:	Work phone:	Hours of employment:
Employer name and address:		Employer name and address:	

Additional Emergency Contacts and People Authorized to Pick-up Child		
Name:	Address:	Phone:
Name:	Address:	Phone:
Name:	Address:	Phone:

☐ **Emergency Medical Care**

I, _____, the parent (or legal guardian) of _____, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

☐ **Transportation**

I, _____, the parent (or legal guardian) of _____, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute.

_____ _____

Signature of parent/guardian Date

Medical Information	
Name of child's physician:	Office phone:
Special medical information, medications, allergies, diet:	Health insurance identification information:

The above information is necessary for your child's protection and this facility is required to have it. Keep this information current.

Created by the DE Office of Child Care Licensing. Revised July 2015. Facility must retain this information for 3 months after child is removed from care.

Instructions to Parent/Guardian:

1. **Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.**
2. **If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.**

Child's Name: _____ Date of Birth: _____

Medical Condition(s):

_____

Medications currently being taken by your child:

_____

Date of your child's last tetanus shot:_____

Allergies/Reactions:_____

Emergency Medical Instructions:

1. Signs/symptoms to look for: _____
2. If signs/symptoms appear, do this: _____

   _____
3. To prevent incidents:_____

   _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

_____
_____
_____

Comments

_____
_____
_____