SOLANO FAMILY & CHILDREN'S SERVICES

421 Executive Court North - Fairfield, CA 94534-4019 – (707) 863-3950 – Fax: (707) 863-3975

FSS Initials

EMERGENCY AND IDENTIFICATION INFORMATION

FAMILY INFORMATION

Child's Name (Last Name): ________________ (First Name): ________________ Date of Birth: ________

Mother's Name: ________________ Phone: ( ) ________ Other: ( ) ________

Home Address: ________________ City: ________ State: ____ Zip: ________

Father's Name: ________________ Phone: ( ) ________ Other: ( ) ________

Home Address: ________________ City: ________ State: ____ Zip: ________

Mother's business address: ________________ City: ________ State: ____ Zip: ________ Work Ph: ( ) ________

Father's business address: ________________ City: ________ State: ____ Zip: ________ Work Ph: ( ) ________

Names of persons authorized to take the child from the facility. (This child will not be allowed to leave with any other person without written authorization from the parent or guardian.)

	NAME	ADDRESS	TELEPHONE#	RELATIONSHIP
1)				
2)				
3)				

ILLNESSES – Check those illnesses that the child has had and give approximate date of illness(es)

	Date		Date		Date
Chicken Pox	____ / ____	Diabetes	____ / ____	Poliomyelitis	____ / ____
Asthma	____ / ____	Epilepsy	____ / ____	Ten-Day Measles	____ / ____
Rheumatic Fever	____ / ____	Whooping Cough	____ / ____	Three-Day Measles	____ / ____
Hay Fever	____ / ____	Mumps	____ / ____		

MEDICAL INFORMATION

Are your Child's Immunization Shots up to date? ❒ Yes ❒ No **Please attach a copy of his/her immunization record to this form.**

Is your child currently taking medication? ❒ Yes ❒ No Medications: ________________

What is the plan for child care when your child is ill? ________________

Describe any medical/physical limitations, illnesses/allergies: ________________

____

Physician to be called in an emergency.

Name: ________________ Phone: ( ) ________

Address: ________________

Preferred Hospital: ________________

If your physician cannot be reached, what action should be taken? ________________

____

____

Dentist to be called in an emergency: ________________

Dental Insurance Carrier: ________________

Patient Identification Number: ________________

Group Number: ________________

Address: ________________ Phone: ( ) ________

Medi-Cal #: ________ Medical Insurance: ________________ Insurance #: ________________

Permission for medical treatment. Administrative procedures vary among medical personnel and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance. *In case of an accident or an emergency, I authorize my child care provider (and staff employed by my provider) to take my child to the above-named physician or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of my child, at my expense.*

Signature: ________________________________ Date: ________________
Parent or Guardian

The purpose of this agency is to promote and advocate for the well-being of children and families in Solano County by providing Subsidized Child Care, Resources & Referrals, Provider/Parent Training and Education, the Child Care Food Program and Community Outreach to address the community's diverse and ever changing needs.