CRYSTAL STAIRS, INC.

EMERGENCY AND IDENTIFICATION INFORMATION

(To be completed by parent or guardian & updated at re-certification & as changes occur.)

I. FAMILY INFORMATION

Parent Name:	Telephone Number:	Family ID #:
Home Address:	City: State: CA	Zip Code:
Spouse's Name:	Spouse's Telephone:	
Spouse's Business Address:	City: State:	Zip Code:

Do both biological parents live in home with the child(ren): ☐ **YES** ☐ **NO**

II. CHILD(REN) INFORMATION

Child 1: _____ D.O.B: _____	Child 2: _____ D.O.B: _____
Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____	Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____
Child 3: _____ D.O.B: _____	Child 4: _____ D.O.B: _____
Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____	Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____
Child 5: _____ D.O.B: _____	Child 6: _____ D.O.B: _____
Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____	Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____
Child 7: _____ D.O.B: _____	Child 8: _____ D.O.B: _____
Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____	Relation to Child: ☐ Parent ☐ Relative ☐ Non-Relative: _____

III. NAMES OF PERSONS AUTHORIZED TO REMOVE CHILD(REN) FROM THE FACILITY / PROVIDER

(This child will not be allowed to leave with any other person without written authorization from parent or guardian.)

Name:	Telephone:	Relationship to child(ren):
Name:	Telephone:	Relationship to child(ren):
Name:	Telephone:	Relationship to child(ren):

IV. PHYSICIANS TO BE CALLED IN AN EMERGENCY INFORMATION

Name of Hospital / Clinic:	Doctor's Name:
Address:	Telephone Number:
City: State: Zip Code:	Do(es) child(ren) have Medical / Medi-cal Insurance: ☐ **YES** ☐ **NO** If "yes", Medical /Medi-cal Insurance Number:

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

VI. ALLERGIES OR OTHER MEDICAL LIMITATIONS:

VII. 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 a staff member of the child development agency 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 the child, at my expense.

Parent or Guardian Signature: **Date**: