Date of enrollment:_____ Date of discharge:_____

Noah's Ark Learning Center

Office use only: Class:_____

Child's Personal Data Sheet

Days:_____

Child's Name _____ Birthdate: ___/____/_____ Gender: Male Female

Primary Caregiver:_____Relationship to child: _____

Email address:_____

Home Address:_____City, State, Zip _____

Home phone:_____ Work phone:_____Cell Phone:_____

Place of employment:_____ Work hours: from _____ to _____

Secondary Caregiver:_____Relationship to child: _____

Email address:_____

Home Address:_____City, State, Zip _____

Home phone:_____ Work phone:_____Cell Phone:_____

Place of employment:_____ Work hours:_____

****Emergency Contact Information:**

Name of person to call if parents cannot be reached:_____

Address:_____ City, State, Zip_____

Home phone:_____ Work phone:_____Cell Phone:_____

Is this person authorized to take the child from Noah's Ark? Yes_____ No_____

**** List all other adults who are authorized to take the child from Noah's Ark:**

Name:_____ Relationship:_____Phone #:_____

Name:_____ Relationship:_____Phone #:_____

Name:_____ Relationship:_____Phone #:_____

****MEDICAL INFORMATION:**

_____

Child's Physician **or** Emergency Treatment Facility Phone number

_____

Address City State Zip Code

I,_____, mother/father/guardian **(circle one)**

of_____(child's name), do hereby give my consent to the Director of Noah's Ark Learning Center, or her duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or her duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

_____

Signature of parent or guardian Date

_____

Witness Date

****Consents:**

I hereby give____/do not give___ the Director or Noah's Ark appointed representative permission to give _____ (Child's Name) Acetaminophen. I understand I will be notified that the medication has been administered.
Signature:_____ Date:_____

I hereby give____/do not give____ written permission for the use of suntan lotions/sunscreen for my child in permitable weather. In accordance with Minimum Licensing Requirements:
Signature:_____ Date:_____

I hereby give _____/do not give _____ Noah's Ark Learning Center permission to take photographs or video tape of my child for use in the facility.
I hereby give_____/do not give_____ Noah's Ark Learning Center permission to place photos and/or video recordings of my child on social media or the Noah's Ark Learning Center webpage.
Signature:_____ Date:_____

****Acknowledgements:**

This is a statement of verification that I have been informed that childcare licensing/child maltreatment investigators and/or law enforcement may possibly interview my child for the purpose of determining licensing compliance or for investigative purposes.
Signature:_____ Date:_____

This is to acknowledge that I have received a copy of or given the website address to the electronic version of a list of Kindergarten Readiness Skills for my child (3,4, and 5 Year olds).
Calendar: https://humanservices.arkansas.gov/wp-content/uploads/Getting_Ready_for_Kindergarten_Calendar._Print_Version_-1.pdf
Checklist: https://humanservices.arkansas.gov/wp-content/uploads/KRIC-PARENT-1.pdf
Signature:_____ Date:_____

This is a statement of verification that I have been informed of the behavior guidance policy practiced.
Signature:_____ Date:_____

This is a statement of verification that I have received information regarding Shaken Baby Syndrome in accordance with Carter's Law (all parents of infants).
Signature:_____ Date:_____

****Pertinent Medical and Developmental Information:**

Immunizations: I have provided a copy of my child's Immunization Record: Yes_____ No _____

Disease history: Measles _____ Mumps_____ German Measles _____ Chicken Pox_____ Whooping Cough_____

Frequent colds: Yes ____ No____
Defective heart: Yes ____ No____
Sun Sensitivity: Yes ____ No____
Fainting spells: Yes ____ No____
Biting: Yes ____ No____
Seizures: Yes ____ No____
Diabetes: Yes ____ No____
Frequent throat infections: Yes ____ No_____
Temper tantrums: Yes ____ No_____
Contracted Tuberculosis: Yes ____ No_____
Frequent ear infections: Yes ____ No_____

Allergies:_____ Medications:_____

Physical or emotional concerns child might have_____

Other conditions or comments:_____

Special food needs: Formula _____ Diabetic diet _____ Other_____

Is child toilet-trained: Yes _____ No_____ Words used in toileting _____

Siblings? Yes _____ No _____ Name (s) and ages of siblings:_____

I, the parent/guardian of this child, understand that I may ask for a conference with the teacher/caregiver(s) as needed.
Signature:_____ Date:_____

I have received a copy of the handbook and agree to the policies therein. Signature:_____