

PHYSICIAN'S NAME _____ PHONE _____

- As the parent, agency representative or legal guardian, I hereby give consent to LAUMC Children's Center to provide all emergency dental or medical care prescribed by a duly licensed physician or dentist for (Child's name) _____. This care may be given under whatever conditions are deemed necessary to preserve the life, limb or well-being of my dependent.

PARENT'S SIGNATURE _____

CHILD'S GENERAL HEALTH

- Has your child had any of the following
Anemia _____ Asthma _____ Hay Fever _____
Diabetes _____ Epilepsy _____ Rheumatic Fever _____

Please list other illnesses, operations or injuries _____

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CHILD'S SOCIAL AND PERSONAL HISTORY (Please share as much information as possible)

Nursery school / Child care experiences _____

Has child had babysitters other than family? _____

Does child have any speech problems? _____

Does child have any special problems or fears? _____

Languages spoken at home _____

Behavior guidance used at home _____

Evaluation of child's personality _____

Additional Comments _____

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EMERGENCY CONTACTS REQUIRED: two people, other than the child's parents, who live at separate households that could arrive at the Children's Center in 10 minutes if necessary.

NAME	ADDRESS	PHONE	RELATIONSHIP
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- I understand that the registration and application fees are non-refundable. I agree to comply with Children's Center policies.

SIGNATURE _____ DATE _____