Phillips County Developmental Center
1221 HWY 49 * 870-572-3417 * Fax 870-572-5130

Child Personal Data Sheet

1. Name: _____ DOB: _____

Father's Name: _____ Mother's Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Father's Employer: _____ Cell Phone: _____ Work Hours: _____

Mother's Employer: _____ Cell Phone: _____ Work Hours: _____

Date Enrolled in Center: _____ Date Withdrawn from Center: _____

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2. Emergency Contact Information

Name of person to call if parents can't be reached: _____

Relationship: _____ Phone(s): _____

City: _____State: _____Zip: _____Phone: _____

Is this person authorized to take the child from the center?_____

_____	_____	_____
Name Relationship	Name Relationship	Name Relationship
_____	_____	_____
Address	Address	Address
_____	_____	_____
City State Zip	City State Zip	City State Zip

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3. Emergency Contact Information

Child's Physician or emergency treatment facility: _____

Address: _____ City: _____ State: _____ Phone: _____

I, _____, ☐ Mother, ☐ Father, or ☐ Guardian

Of_____, do hereby give my consent to the Director of the Child Care Facility or duly representative, for said child to receive medical or surgical aid as may be defined necessary and expedient by licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent given for the

Director or duly appointed representative to transport said child for emergency medical treatment if parents cannot be reached.

Signed: _____ Date: _____ Witness: _____ Date: _____

_____I hereby give_____do not give the Director of the Child Care Facility or his appointed representative permission

to give _____ acetaminophen. I understand I will be notified that the
(Child's Name)
Medicine has been administered.

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4. Immunization. Please provide a copy of your child's immunization record.

Verified by the Health Department Record _____ Physician's Record _____ Other _____

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5. Disease History: List the dates of each.

Measles _____ Mumps _____ German Measles _____ Chicken Pox_____ Whooping Cough_____

Contractual Tuberculosis: Yes____ No____ Frequent Ear Infections: Yes____ No____

Frequent Throat Infection: Yes____ No____ Defective Heart: Yes____ No____

Other Conditions or Comments: _____

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6. Child's Developmental Needs:

Physical or Emotional problems that the child have: _____

Child's special food needs: Formula_____ Diabetic/diet_____ Allergies_____

problems: Medications: _____

Allergies_____ Temper Tantrums_____ Diabetes_____ Frequent Colds_____ Biting_____

Sun Sensitivity _____ Seizures _____ Fainting Spells _____ Bed Wetting_____ Other _____

Requires help in: Dressing _____ Undressing _____ Toileting_____ Eating_____ Washing Hands_____

Is the child toilet trained? Yes_____ No_____ Words used in toileting_____

Favorite: Games _____ Toys _____ Foods _____

Siblings? Yes____ No____ Name(s) of siblings:_____

Type of child care used before: _____

Other useful information: _____

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7. I, the parent or guardian of this child, understand that I may ask for a conference with caregiver(s) as needed:

_____ _____
Signature Date