CDC/SGH# or name:_____

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Mother or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

Father or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	**Contact Telephone Number**:
Name:	**Contact Telephone Number**:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):_____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? ☐ **No** ☐ **Yes** **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	
Is child usually susceptible to infections and if so, what precautions need to be taken? ☐ **No** ☐ **Yes** **If yes**, list precautions:	
Is child subject to convulsions and what should be our procedure if one occurs? ☐ **No** ☐ **Yes** **If yes**, specify procedure:	
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? ☐ **No** ☐ **Yes** **If yes**, list precautions:	
Additional comments:	
Other special instructions:	

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**

14/15 Teacher_____ Grade_____ School_____

NEW ☐

Returning ☐

CATALINA FOOTHILLS COMMUNITY SCHOOLS
C.A.R.E. INFORMATION CARD

ck #_____

charge initials_____

CHILD'S NAME _____ date_____

PERSONS AUTHORIZED, ON A REGULAR BASIS, TO PICK UP CHILD: (include parent(s) and/or guardians(s))

NAME_____ SIGNATURE_____

NAME_____ SIGNATURE_____

NAME_____ SIGNATURE_____

I give CARE staff permission to sign my child out of the morning CARE program to attend school and/or permission to sign my child into the CARE program after school._____yes_____no

In case of emergency, with my telephone authorization, CARE has permission to release my child to a designated person (photo I.D. required) other than the above authorized people. _____yes _____no

Does your child have any health problems the staff should be aware of?_____
Does your child require medication on a regular basis?_____ (This will require special arrangements with the CARE staff)
What medication is required?_____ For what condition?_____

A $75.00 nonrefundable registration fee for the first child is due upon registration; a $45.00 fee will be charged for each additional child.

_____ _____
Signature of Parent or Guardian Date signed

E-mail address (for calendar due date reminders): _____

EMERGENCY INFORMATION AND RELEASE

Should your child be injured while participating in the Community Schools CARE Program, you will be notified immediately. If there is no answer at the residence or no one available at the work numbers, the emergency numbers listed will be called. If medical treatment is necessary, and there is no answer at any of the aforementioned numbers, the staff will assume responsibility for the appropriate measures. However, Catalina Foothills Community Schools is not responsible for any medical or related fees resulting from such treatment. Please read and sign the following:

I recognize the risks of illness and injury inherent in any child care program and am participating upon the express agreement and understanding that I am hereby waiving and releasing the instructor and Catalina Foothills Community Schools from and against any and all claims, costs, liabilities, expenses or judgments, including attorney's fees and court costs arising out of my participation in the program.

I hereby agree to the above statement and am releasing the Community Schools and anyone associated with it of any financial and/or medical obligation which might be incurred.

Child's name_____

_____ _____
Signature of parent or guardian Date signed

CREDIT CARD AUTHORIZATION

If you would like to make your C.A.R.E. payments with a credit card, please complete this form and return it to our office, 2101 E. River Rd. We will keep your card number securely on file. With each CARE calendar that you submit you will need to authorize our office to use this credit card for payment by signing at the bottom of the calendar. Additional fees from overtime or added hours will also be added to the charge amount.

My (our) signature(s) authorizes Catalina Foothills School District Community Schools to charge the C.A.R.E. Program tuition, fees and outstanding balances to the credit card listed for the school year I am registering.

_____ _____

Signature Date

_____ _____

Signature Date

Print names of authorized user(s) of this card:

_____

_____

Phone Number(s): _____

Please circle: VISA MASTERCARD DISCOVER

Credit card number_____ - _____ - _____ - _____

Expiration date _____ / _____

Children's Names: _____

_____

_____

School _____ School Year _____

To the best of your ability please provide us with your child's need for C.A.R.E. for the 2014-2015 school year. Please circle your needs.

1 day a week AM / PM / BOTH
M T W TH F

2 days a week AM / PM / BOTH
M T W TH F

3 days a week AM / PM / BOTH
M T W TH F

4 days a week AM / PM / BOTH
M T W TH F

5 days a week AM / PM / BOTH
M T W TH F

Child's name_____

School_____

Grade_____

This form needs to be attached to each registration form you submit.