

3. Arkansas Department of Human Services
Division of Children and Family Services
Child's Personal Data Sheet 2021-2022

1. Personal Data Information

Child _____ Male/Female _____ DOB _____
Parents Names _____ Married/Not Married _____
School _____ Grade _____
Address _____
City _____ State _____ Zip _____
Mom Cell Phone _____ Dad Cell Phone _____
Email address _____
Parent 1 Employer _____ Phone _____ Hours _____
Parent 2 Employer _____ Phone _____ Hours _____
Date Accepted to Center _____ Date Withdrawn from Center _____
Name of Center St.James UMC Kids LIFE
321 Pleasant Valley Drive, Little Rock, AR 72212 Hours in Care _____

2. Emergency Contact Information

Name of Person to call if parents cannot be reached _____
Two Phone Numbers _____ Relationship _____
Address _____
Is this person authorized to take child from center? _____
List all other adults authorized to take child from center:

1. _____
Name Relationship to child

Address City State Zip Code

Home Phone Cell Phone Work Phone

2. _____
Name Relationship to child

Address City State Zip Code

Home Phone Cell Phone Work Phone

3. Medical Information

Child's Physician _____ Address _____ Phone _____
Preferred Emergency Room _____

Consent for emergency medical care

I, _____, mother, father, or guardian of _____ do hereby request and give consent to the Director of the Day Care Facility, or his duly appointed representative for said child to receive such 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 his duly appointed representative to transport said child for emergency medical treatment if the parents cannot be reached.

Witness Parent

Date Date

(circle one)

I hereby GIVE DO NOT GIVE the Director of Kids LIFE, or her appointed representative, permission to give **Children's Tylenol** to:

(child's name) _____

I understand I will be notified that Tylenol has been administered.

(Parent signature) _____

TURN OVER

Disease History

Measles German Measles Whooping Cough

Mumps Chickenpox

Contracted Tuberculosis _____ Frequent Ear Infection _____

Frequent Throat Infection _____ Defective Heart _____

Other Conditions or Comments _____

Medications (please list) _____

Child's Abilities

Child's special abilities _____

Physical or emotional problems the child might have _____

Child's special food needs _____

Diabetic Diet _____ Food Allergies _____

Special Problems: Sunburn sensitivity Frequent Colds

Allergies Temper Tantrums Diabetes Biting

Seizures Fainting Spells Bed Wetting

Other _____

Does child need help in: Dressing Undressing Toileting

Eating Washing Hands

Favorite Games _____ Toys _____ Foods _____

Brothers? _____ Sisters? _____

Type of child care before? _____

Other Information or Comments _____

Are the parents/legal guardians of the child or anyone who may have responsibility for coming to the school to pick up the child or participate in school activities (e.g., holiday celebrations, school performances, or other special events) either (a) a registered sex offender or (b) someone previously charged with child abuse, neglect, sexual molestation, or any crime of a sexual nature?

[Circle YES or NO]

If yes, please explain: _____

[St. James United Methodist Church has a Safe Sanctuary Policy which seeks to provide a safe sanctuary for children. A copy of this policy is available upon request.]

With this signature, I acknowledge that all the provided information is correct to my knowledge, and that I, parent/ guardian of this child, understand I may ask for a conference with caregiver(s) as needed.

_____ (parent signature) _____ (date)