THE LITTLES

NOTES:

OUR HOME ADDRESS:

PARENT CELL

PARENT CELL

CLOSEST NEIGHBOR PHONE

FAMILY/FRIEND PHONE

DOCTOR PHONE

DENTIST PHONE

FIRE PHONE

POISON PHONE

IN CASE OF EMERGENCY, CALL 911

THE LITTLES

NAME DATE OF BIRTH / /

INSURANCE PHONE

POLICY #

ALLERGIES

NAP-TIME/BEDTIME

NOTES

NAME DATE OF BIRTH / /

INSURANCE PHONE

POLICY #

ALLERGIES

NAP-TIME/BEDTIME

NOTES

NAME DATE OF BIRTH / /

INSURANCE PHONE

POLICY #

ALLERGIES

NAP-TIME/BEDTIME

NOTES

NAME DATE OF BIRTH / /

INSURANCE PHONE

POLICY #

ALLERGIES

NAP-TIME/BEDTIME

NOTES

MEAL TIME: BATH ROUTINE? YES ☐ NO ☐ SCREEN TIME OK? YES ☐ NO ☐ HOW LONG?

PET FEED? ☐ TIME WALK? ☐ TIME

THE LITTLES

WE WILL BE AT: _____

ADDRESS: _____

_____

PHONE: _____

NOTES: _____

_____

_____

MEDICAL CONSENT | The person named below must be 18 years of age or older

I, _____, being the parent and/or legal guardian of _____ (hereinafter, my child(ren) so hereby authorize _____ to seek and obtain medical care for my child(ren) in the event that my child(ren) need(s) medical care. **Allergies: please refer to individual childs information.**

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this authorization.

This form is ONLY VALID during the following time-frame: Effective Date _____ Expiration Date _____

My health insurance carrier is: _____

Our policy number is: _____

Signature of parent (or Legal Guardian) _____ Date _____

Witness Signature _____ Date _____

☐ COPY OF INSURANCE CARDS ATTACHED ☐ COPY OF PARENT/LEGAL GUARDIAN DRIVERS LICENSE ATTACHED