

# Our Shepherd Lutheran School

~ Dare of Admission	Date of Discharge	<b>ABC Program Child Information Record</b>	
		<b>One form per child - Required</b>	
Name of Child (Last, First, Middle Initial)		Address (Number and Street, Building/Apartment Number)	
Child's Date of Birth	Home Phone Number (    )	City	State    Zip Code
Father/Legal Guardian's Name:		Mother/Legal Guardian's Name:	
Father's Home Address: (If not child's address)		Mother's Home Address: -(If not child's address)	
Father's home phone		Mother's home phone	
City	State	Zip Code	City
			State
			Zip Code
Employer / School Name		Employer / School Name	
Address (Employer / School Address)		Address (Employer / School Address)	
City	State	Zip Code	City
			State
			Zip Code
Employer / School Phone:	Hours of Employment / School	Employer / School Phone:	Hours of Employment / School
Name of Local Person to be Notified in an Emergency When Parent is not Available:		Local Address and Phone Number of Emergency Person	
Home Phone	Work Phone	City	State
			Zip code
Name(s) of Person(s) other than Parent or Legal Guardian to whom child may be Released			
Cell phone: Mother _____		Cell phone: Father _____	

I give permission to	<b>ABC Program Staff</b>	licensed by the Department of Consumer and
Industry Services to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.		
Signature of Parent or Guardian	Date Signed	AUTHORITY: Act 116 of p..A. 1973. COMPLETION: Required: PENALTY: Rule Violation Citation.
Space is for Notarization (if required by Local Medical Facility)		

**\*\*Please be sure to include the Address and Zip of you child's Physician\*\***

Name and Address of Child's Physician or Health Clinic	Zip Code	Phone Number
Hospital Preferred for Emergency Treatment		Health Insurance Policy Name and Number
Allergies, If any		Date of Last Tetanus Shot

The Michigan Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

# Our Shepherd

## ABC Program Child Information Record

### Health Appraisal Form

I certify that my child \_\_\_\_\_ is in good physical health without any health restrictions (unless specified below) and that the child's immunizations are up to date.

\_\_\_\_\_  
Parent's Name

\_\_\_\_\_  
Date