RIT | Division of Student Affairs
Margaret's House

Early Childhood Programs at Rochester Institute of Technology
112 Lomb Memorial Drive, Rochester, NY 14623
585-475-5176

Child's Full Name **Birthdate**

Child's Home Address

Child's Home Phone Number

Parent/Guardian: **Cell Phone:** **Work Phone:**

Parent/Guardian: **Cell Phone:** **Work Phone:**

Email: **Email:**

Emergency Contact	Name	Relationship	Phone Number during Child Care	Other Phone Number	Authorized to Pick Up (Y/N)
1					
2					
3					
4					

** You must have at least one emergeny contact listed that is not a parent/guardian*

Not Authorized for Pick Up:

MEDICAL:

Does your child have any allergies? **Yes** **No**

If yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral, or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special healthcare needs, please discuss these with your child-care provider. If your child has an allergy, we require you to complete the **ALLERGY EMERGENCY PLAN** on our website.

Source of Medical Care/Primary Care Physician: **Phone:**

Medical Care Facility/Hospital: **Phone:**

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: nystateofhealth.ny.gov

AGREEMENTS:

I give consent for my child to take part in campus trips (i.e. library, nature trail) away from the facility under proper supervision. **Yes** **No**

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon, or hospital necessary for the proper health and well-being of my child. **Yes** **No**

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. **Yes** **No**

I agree to review and update this information whenever a change occurs and at least once every six months. **Yes** **No**

CONSENTS:

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding the administration of medications, fees, transportation, and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

Unless otherwise indicated, the parent/guardian(s) will serve as primary emergency contacts and authorized pick-up person(s). Please notify staff in advance if anyone other than parent/guardian(s) will be picking up your child.

Signature of Parent/Guardian: **Date:**

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Parent/Guardian Name:				
Parent/Guardian Relationship:				
RIT Affiliation (check all the apply):		Faculty	Department:	
		Staff	Position or Department:	
		Alumni	Class Year:	
		Student	Anticipated Grad. Year:	
		None		
If none, name of non-RIT employer:				

Parent/Guardian Name:				
Parent/Guardian Relationship:				
RIT Affiliation (check all the apply):		Faculty	Department:	
		Staff	Position or Department:	
		Alumni	Class Year:	
		Student	Anticipated Grad. Year:	
		None		
If none, name of non-RIT employer:				

Date Updated:	

OFFICE USE ONLY	
Start Date:	Date of Discharge: