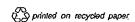
CHILDREN'S RECORD Nebraska Health and Human Services System



Child(ren)'s Name:		Birthdate	Birthdate(s):				
Enrollment Date:		Last Enro	•				
Parent or Guardian's H	lome Address and Employ	ment Address:					
FATHER (or Guardian):	e e			,			
Name:	· ·	Employer	:				
Address:		Address:_					
City:	Phone:	City:		Phone:			
MOTHER (or Guardian):		•	:				
Name:		Employer;	A SECTION OF SECTION S	andria (1900) Andria (1900)			
Address:		Address:	A SHOW THE STATE OF	美国各种的			
City:	Phone:	City:		Phone:			
Person(s) to Whom the	Child(ren) may be Release	ed by the Caregiver: (if	no one, please write	ë "none")			
Name:		Name:	y with the second				
Address:		Address:_					
City:	Phone:	City:					
Person(s) Who Will Take	Responsibility for the Cl	nild(ren) in an Emerge	ency When the Pare	ent (or Guardian) Cannot b			
	UST BE GIVEN)	•					
	The second secon	والمقارع والمعاصو ووالمصاب والمنزمين	on the second of	•			
Address:		Address:					
Dity:	Phone:	City:		_ Phone:			
onsent to Contact Phys	sician in Emergency:		* t				
the event I cannot be rea	ached to make arrangemen	ts, I hereby give my con	sent to	Coronivor			
		to contact Doctor	<u> </u>	caregivere of Physician			
		- 1, ten	· Nam	<u></u>			
Phone nd, if necessary, take my	child(ren) to the following do	Address octor(s), clinics, or hosp	ital	City			
	94 ST			· · · · · · · · · · · · · · · · · · ·			
			e de la companya de La companya de la co				
	Signature of Parent/Guardian	****		Date			





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Transportat	ion Permission				
I hereby give					_permission to transport o
arrange for tr	ansportation of my	Name of child	Facility		
	staff will insure that r		N:	ame of Child(ren) restraint as indicated by	Nebraska law at all times th
	Signat		Date		
Medication C	ompetency State	ment		The state of the s	
l,					have determine
		Parent /Gua	ırdian Name		
		Provider/Director	com	petent to give or apply I	medication to my child(ren)
		· Toviden Director			
	Sign	nature of Parent/Guardian			Date
		CHILD'S M	EDICAL INFORM	ATION	
Any health prob	olems which caregi	ver should know:		44-31-10-10-10-10-10-10-10-10-10-10-10-10-10	
			,		
	·	"			•
				-	
		T engage in:			
Company provid	ling health and/or a	accident insurance cove			
Certificate of Im	munizations				•_
•		Month ar	nd Year of Each Dos	e	
DTaP 1	IPV 1	HIB 1	MMR 1	HEP B 1	VZV 1
DTaP_2	IPV 2	HIB 2	MMR 2	HEP B 2	VZV 2
DTaP 3	IPV 3	1		HEP B 3	
DTaP 3	IPV 4	HIB 4_			
DTaP 5	· .		To Art gaset to a		•
OTaP - Includes	DtaP and DTP (I DT (Diphtheria, 1 Td (Tetanus, Dip OPV (Oral Polio) IPV (Injectable P	Vaccine)	MMR - Hep B	Haemophilus Influenzae - Measles, Mumps, Rub Hepatitis B Varicella	
	I certify th	nat the above informati	on is correct to the b	est of my knowledge.	
				•	
	Signature of Paren	VGuardian or Physician		· · · · · · · · · · · · · · · · · · · 	Date