ADHS

CENTER # (state): _____

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	Date Enrolled:	Updated:
Home Address (# Street, City, State, Zip Code):		Date Discarded:
Home Phone:	Date of Birth:	Sex: ☐ male ☐ female

Parent or Guardian Name:	Home Address (# Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Parent or Guardian Name:	Home Address (# Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted. (Pursuant to R9-5-506.B, at least two emergency contact persons are required.)

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:

* A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional): _____