



Arizona Department of Health Services

Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

CCL-0024-01-0000 _____

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

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

Parent or Guardian Name:	Home Address (H. 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 (Parent or 24-hr. H.H., at least two 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:
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*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:

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

Telephone Authorization Code (optional): _____