

## CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

<b>For Provider Use Only:</b>		Date of Admission	Date of Discharge
Name of Child (Last, First, Middle Initial)			Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State Zip Code
Parent/Guardian's Name	Home Phone	Parent/Legal Guardian's Name	Home Phone
Home Address (if not child's address)	Cell Phone	Home Address (if not child's address)	Cell Phone
Do you accept text messages? Y                      N		Do you accept text messages? Y                      N	
City	State	Zip Code	City State Zip Code
Email Address		Email Address	
Employer Name	Work Phone	Employer Name	Work Phone
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number	
Hospital Preferred for Emergency Treatment (optional)			
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)			

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

<b>Emergency Contact &amp; Release of Child:</b> List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)		
1.	Phone Number 1	Phone Number 2
2.	Phone Number 1	Phone Number 2
3.	Phone Number 1	Phone Number 2
<b>Release of Child Only:</b> List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)		
1.	Phone Number	2. Phone Number
3.	Phone Number	4. Phone Number

I give permission to <u>U-M Towsley Children's House</u> , licensed by the Department of Human Services <small>(Provider's Name)</small>	
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

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials
Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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