Learning Center Data Entry Form

Child Information:
Full Name: _____ Gender: ____ Birth Date: _____
Enrollment Date: _____

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Primary (Enrolling) Guardian:

Name: First_____ Last_____ Gender: _____
Relationship to child: _____
Address: _____
City: _____ State: _____ Zip: _____
County: _____ Birth Date: _____
Phone: _____ Secondary Phone: _____
Email: _____ Employer: _____
Employer Address: _____
Work Phone: _____ Work Schedule: _____

Secondary Guardian:

Name: First_____ Last_____ Gender: _____
Relationship to child: _____
Address: _____
City: _____ State: _____ Zip: _____
County: _____ Birth Date: _____
Phone: _____ Secondary Phone: _____
Email: _____ Employer: _____
Employer Address: _____
Work Phone: _____ Work Schedule: _____

Authorized People for Pick- up and Emergency Contact Listed in Order of Priority

Full name: _____
Relation to child: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary phone: _____
Secondary phone: _____

Full name: _____
Relation to child: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary phone: _____
Secondary phone: _____

Full name: _____
Relation to child: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary phone: _____
Secondary phone: _____

Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

*Please note, if no physician is listed, we will contact Children's Health Care in case of emergency.

Dentist Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

*Please note, if no physician is listed, we will contact Children's Dental Care in case of emergency.

Allergies:

_____

_____

_____

Medical Concerns:

_____

_____

_____

Is your child currently taking any medications? Yes _____ No_____
If yes please list:

_____

_____

_____

Margaret Mary Health
Batesville, INDIANA

I (We) the undersigned parents, or legal guardians of (name of child) _____, a minor, authorize treatment of my (our) child by a licensed medical physician on staff at Margaret Mary Health and or any hospitalization that is necessary in case of an accident or illness. This consent form will remain effective until revoked in writing by the undersigned.

Blood Type, Surgical History, and Date of Last Tetanus:

_____

_____

Insurance Company_____

Policy Number _____

I (We) understand that this consent authorization is given in advance of any specific diagnosis or hospital care being required in order to provide authority to Margaret Mary Health to render and all diagnosis, treatment, or hospital care deemed advisable by the physician attending the child in case of an accident or injury.

AUTHORIZATION SIGNATURE

Guardian 1_____Date_____

Guardian 2_____Date_____