



RETURNING CHILD: UPDATE FORM

*Only changes need to be completed

STUDENT INFORMATION						
Student's Name Last	First	Middle	Gender	Date of Birth	Start Date	Exit Date
Street Address				City	State	Zip
How did you hear about SCP?						
PARENT/GUARDIAN INFORMATION						
Parent/Guardian Name Last					Relationship to Student:	
Street Address					City	State
Home Phone	Cell Phone	Work Phone		Email		
Employer	Employer Address			City	State	Zip
Parent/Guardian Name Last					Relationship to Student:	
Street Address					City	State
Home Phone	Cell Phone	Work Phone		Email		
Employer	Employer Address			City	State	Zip
EMERGENCY CONTACTS						
The emergency contacts are always authorized for pick-up of child in case of emergency. (ID required for pickup)						
Name		Address			Phone Numbers	
Full Name:					Home:	
Relationship:					Cell:	
Full Name:					Home:	
Relationship:					Cell:	
Full Name:					Home:	
Relationship:					Cell:	
Full Name:					Home:	
Relationship:					Cell:	
<i>If you need to add more emergency contacts, please inquire about an additional form.</i>						
ADDITIONAL FAMILY INFORMATION						
Please let us know about shared custody situations so we can be sensitive to your child.						
Is there a restraining order in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, court documentation must be on file with SCP for enforcement).</small>						
Is there is parenting plan in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, court documentation must be on file with SCP for enforcement).</small>						



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HEALTH HISTORY			
Doctor's Name:	Address:	Phone Number:	Last Physical Exam Date:
Dentist Name:	Address:	Phone Number:	Last Dental Exam Date:
Insurance Company Name:		Member/Policy Number:	
Policy Holder Name:		Employer Name:	
INDIVIDUAL HEALTH CARE PLAN: Does your child have a life-threatening medical condition, severe allergies, or significant health/development concerns? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes please explain below</i> If you answered yes to any of the questions below, you will be contacted regarding other required forms. Forms/on-site training must be completed and submitted no later than a week before start date.			
Please check all that apply to your child: <input type="checkbox"/> Food Allergies <input type="checkbox"/> Medical Allergies <input type="checkbox"/> Other Allergies <input type="checkbox"/> Developmental Needs (Speech/PT/OT) Does your child have an Epi-Pen or Inhaler? <input type="checkbox"/> YES <input type="checkbox"/> NO			
I will provide a daily snack due to my child's food preferences. Initials: <input type="text"/>			
If snack is not provided from home, SCP will provide a snack. Initials: <input type="text"/>			