NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**Emergency Reservation Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child’s Full Name: |  | Date of Birth: | /       / | Gender: |  |

**Instructions**

* To be completed by parent/guardian prior to emergency reservation.
* A parent/guardian signature is required.

**The following questions must be answered:**

Yes  No Within the last 14 days, has your child traveled to a country that the federal Centers for Disease

Control and Prevention said should be avoided for nonessential travel or where travelers should

practice enhanced precautions? (China, Iran, Italy, South Korea, Japan)?

Yes  No Has your child had contact with any **person with known COVID-19 or person under**

**Investigation for COVID-19**?

Yes  No Does your child have any symptoms of a respiratory infection (e.g., cough, sore throat, fever, shortness of breath)?

Yes  No Are you or anyone in your home in active quarantine status?

Yes  No Is your child enrolled in a school or child care program?

If yes, please provide the name(s) of your child’s school and/or child care program:

Yes  No Is your child’s school under mandatory closure due to a confirmed case of COVID-19?

Yes  No Is your child’s current program under mandatory closure due to a confirmed case of COVID-19?

**Contact Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Home Address: | | | |
| Parent’s Name and Address (if different than child): | | | |
| Parent’s phone contact (home, cell and work): | | | |
| **EMERGENCY CONTACT NAMES/ADDRESSES** | **Authorized to**  **Pick Up Child** | **PRIMARY PHONE NUMBER**  **(****)** **-** | **OTHER PHONE NUMBER/EMAIL**  **(     )       -** |
| Primary Contact: | Yes  No | ok to text | ok to text |
| Emergency Contact: | Yes  No | ok to text | ok to text |
| Emergency Contact: | Yes  No | ok to text | ok to text |

|  |  |
| --- | --- |
| **Health Specifics** | **Comments** |
| Does your child have any allergies? (Specify)  Yes  No |  |
| Is medication regularly taken?  Yes  No  (Specify diet and condition) |  |
| Is a special diet required?  Yes  No |  |
| Are there any hearing, visual or dental  Yes  No  conditions requiring special attention? |  |
| Are there any medical or developmental  Yes  No  conditions requiring special attention? |  |

**Child’s Healthcare Provider Information**

|  |  |
| --- | --- |
| Child’s Primary Care Physician’s Name/Group: | Phone )Number:  (     )       - |
| Preferred Hospital: | Phone Number:  (     )       - |
| Child’s Dental Care: | Phone Number:  (     )       - |

**Agreements**

|  |
| --- |
| * I consent to emergency medical treatment for my child.  Yes  No * My child is up to date with required immunizations.  Yes  No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **The above information regarding my child’s health is true and accurate. To the best of my knowledge, my child is free from contagious and communicable disease and is able to participate in this program.** | | | | |
| **Parent/Guardian Signature:** | |  | **Date:** | **/** **/** |
| **Printed Name:** |  | | | |