

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
EMERGENCY RESERVATION FORM

Child's Full Name:	Date of Birth: / /	Gender:
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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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
Emergency Contact:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
Emergency Contact:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text

Health Specifics

Comments

Does your child have any allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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:	