



Student Information Update Form

The Little Hippo Child Development Center /Hutto ISD, Hutto, TX 78634

Child's Name: _____ Date of Birth _____ Age _____

Male: ___ Female: ___ Child resides with: Both Parents ___ Mother ___ Father ___ Guardian ___

Parent/Guardian

Name _____ Relationship to Child _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Place of Employment _____

Parent/Guardian

Name _____ Relationship to Child _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Place of Employment _____

Emergency Contacts and Authorization to Release Child: Please list 2 people who can be contacted in the event of an emergency if parents/guardians are unavailable. These individuals must have your permission to pick up your child if necessary.

Contact #1 _____ Relationship to Child _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Contact #2 _____ Relationship to Child _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Special Needs? No _____ Yes _____ If yes, please explain

Allergies? No _____ Yes _____ If yes, please explain

Daily Medications? No _____ Yes _____ If yes, please explain

Name of Medication: _____ Dosage: _____ Frequency _____

Are there any other medical conditions or concerns we should be aware of? No ___ Yes ___

If yes, please provide information regarding symptoms, special care requirements, etc.:

Immunization Record is current/updated and on file with The Little Hippo CDC?

No_____ Yes_____ Parent initials: _____

Authorization for Emergency Medical Treatment

In the event I cannot be reached to make arrangements for emergency medical attention at the time of an illness or accident, I hereby authorize the child care staff or other designated Hutto ISD employee to administer first aid/CPR and/or take my child to the following hospital or clinic for medical treatment. If emergency medical transport is required, I understand that my child may be taken to the nearest emergency medical facility which may not be the same as the hospital/clinic I have listed below

Name of Physician_____ Phone_____

Address_____

Name of Hospital or Clinic _____ Phone_____

Address_____

Photo Permission: (brightwheel, newsletters, etc.)

Parent Approval: Yes ___No___ Parent Initials: _____

Signature of Parent of Legal Guardian

Date