

Dyeann's House, Inc.
A Project of the Jonesboro Area Lions Clubs
A Non Profit Corporation

Admittance Data Sheet

Child's Name: _____ Date of Birth: _____

Father's/Guardian's Name: _____ Phone Number: _____

Mother's/Guardian's Name: _____ Phone Number: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Medical Referral by: _____ M.D.

Emergency Contact Information

Emergency Contact Person: _____

Relationship to child: _____ Phone Number: _____

Is this person authorized to take child from center? Yes No

Authorized person(s) to pick up child from center:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Personal/Medical Information

Child's Physician: _____ M.D. Phone Number: _____

Is the child allergic to anything? If so, please list: _____

List any special needs child might require: _____

Is child aware of parent/guardian condition? Yes No N/A

Religious Preference (optional): _____

Would you like for Dyeann's House to provide counseling to your child? Yes No N/A

Child's Abilities

Special Abilities: _____

Physical or emotional problems: _____

Special dietary requirements: _____

Does your child have any of the following? (Please circle)

Sunburn Sensitivity

Temper Tantrums

Diabetes

Frequent Colds

Biting

Seizures

Fainting Spells

Bed Wetting

Other: _____

Toilet trained? Yes No Plays well with other children? Yes No

Favorite games: _____

Favorite toys: _____

Favorite foods: _____

Any brothers or sisters? _____

List any information that can help us better assist your child: _____

Consent for Emergency Medical Care

I, _____, the (circle) Father, Mother, Guardian, of _____
Do hereby request and give consent to the Administrator of Dyeann's House, or his/her duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician/surgeon in case of emergency when the parent(s)/guardian(s) cannot be reached. Consent is also given for the

Administrator or his/her duly appointed representative to transport said child for emergency medical treatment, if the parent(s)/guardian(s) cannot be reached.

Signed: _____ Date: _____

Immunization History

Please note the month and year child received the immunizations listed below.

Required

DPT & Oral Polio (1-2 Mo) _____ DPT & Oral Polio (3-4 Mo) _____

DPT & Oral Polio (5-6 Mo) _____ Measles/Rubella (15-18 Mo) _____

Recommended

DPT & Oral Polio (Booster 4-6 years) _____

Disease History

Measles: _____ Mumps: _____ German measles: _____

Chickenpox: _____ Whooping Cough: _____ Ear Infections: _____

Contracted Tuberculosis: _____ Throat Infections: _____ Defective Heart: _____

Thank you for entrusting Dyeann's House with your child. Our commitment to you is that we will offer the support, care, and love that is needed by every child especially during time of sickness and illness. Please be assured that Dyeann's House respects the sanctity of life and the gift of each child. We the Lions of Jonesboro are happy to provide these services free of charge.
We wish you the very best!

Parent/Guardian Signature: _____ Date: _____

Dyeann's House
The Home Away From Home

“We Serve”
(Form Revised 05/07)