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? (Specify diet and condition) ☐ Yes ☐ No	
Is a special diet required? ☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention? ☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention? ☐ Yes ☐ 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:	