Arizona State University
Infant Child Research Programs

200 E. Curry Rd. Suite 146 (480) 965-9396
P.O. Box 871908 FAX (480) 965-0965
Tempe, AZ 85287-1908

GENERAL AND EMERGENCY INFORMATION

Child's Name:_____ Nickname:_____
Date of Birth:_____ Chronological Age:_____ Gender: Male ☐ Female ☐

Form Completed By:_____ Date Completed:_____
Relationship to Child:_____
Persons authorized to pick child up from the ICRP:_____
_____

Address:_____
Home Phone:_____ e-mail:_____ Work Phone:_____
Email Address:_____
Physician:_____ Phone:_____
Address:_____

Does your child have any allergies? ☐ Yes ☐ No
If yes, please list_____

Does your child receive any medication? ☐ Yes ☐ No
If yes, please list_____

Does your child have any activity limitations? ☐ Yes ☐ No
If yes, please describe_____
_____

Please provide a copy of your child's current immunization record.

In case of emergency, please contact:_____
Phone:_____ Address:_____
_____

I give permission for my child to be taken to the emergency room in case of an accident.
☐ Yes ☐ No

I give my permission for my child to participate in ICRP sponsored field trips. I understand that I will be notified prior to activities.
☐ Yes ☐ No

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I give permission for my child to travel in a parent or ICRP staff member driven car for ICRP sponsored field trips.

☐ Yes ☐ No

I give my permission for my child to participate in videotaping or photographs for educational and informational purposes.

☐ Yes ☐ No

I give my permission for my child's picture to be posted on the ICRP website. I understand that my child will not be identified by name.

☐ Yes ☐ No

Please list the names and contact information for physicians, clinics, schools, teachers, therapists, or other professionals that are involved with or are providing services to your child. Please indicate if you would like each person listed to receive a copy of your child's evaluations, progress reports, etc.

Name/Agency	**Address** street address city, state zip code	**Phone**	**Copy of reports?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

I give my permission for ASU Infant Child Research Programs to request/release information concerning my child's communication and learning abilities to the persons or agencies listed above. ☐ Yes ☐ No

Signature of Parent/Guardian:_____ Date:_____

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Please provide directions to your home from the ICRP/ASU as well as a travel-time estimate below.

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