



# BABYSITTER INFORMATION

Parent's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

In Emergency contact: \_\_\_\_\_

\_\_\_\_\_

Neighbors: \_\_\_\_\_

\_\_\_\_\_

Where we can be reached: \_\_\_\_\_

Time we are expected back: \_\_\_\_\_

## MEDICAL INFORMATION

Age: \_\_\_\_\_ Approximate Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

Insurance: \_\_\_\_\_

Medicine(s): \_\_\_\_\_

## IMPORTANT PHONE NUMBERS

EMERGENCY: **911**

Hospital: **Elliot Hospital 603.669.5300**

Pediatrician: \_\_\_\_\_

Elliot-On-Call: **603.663.4567**

Poison Control: **800.222.1222**

## WHERE TO FIND

First-Aid Supplies: \_\_\_\_\_

Batteries: \_\_\_\_\_

Fire Extinguisher: \_\_\_\_\_

Flashlight/Candles: \_\_\_\_\_

Electrical/Fuse Box: \_\_\_\_\_

Thermostat(s): \_\_\_\_\_

## ROUTINES

Favorite Activities: \_\_\_\_\_

\_\_\_\_\_

Major Fears: \_\_\_\_\_

\_\_\_\_\_

Nap Schedule: \_\_\_\_\_

\_\_\_\_\_

Feedings: \_\_\_\_\_

\_\_\_\_\_

Bedtime Routine: \_\_\_\_\_

\_\_\_\_\_

Comforting Likes: \_\_\_\_\_

\_\_\_\_\_

Miscellaneous Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## BABYSITTER INFORMATION

I (we) the undersigned parent(s) guardian(s) of the minor(s) listed below, do hereby authorize the emergency department physician in charge at **Elliot Hospital** to act in my (our) place to consent to all necessary and appropriate x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or supervision of any physician or surgeon licensed to practice medicine under the laws of the State of New Hampshire.

It is understood that this authorization, which is valid for days from the date below unless sooner terminated, is given in advance of any specific diagnosis, treatment or hospital care, but is given to provide authorize and power on the part of my (our) aforesaid(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of their best medical judgment is deemed advisable, and is within sound medical practice in the community and is the in the best interest of the child(ren).

I (we) assume all financial responsibility for the delivery of such care.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date From: \_\_\_\_\_ To: \_\_\_\_\_

Children's Physician: \_\_\_\_\_

Child's Name: \_\_\_\_\_