

CHILD CARE REGISTRATION FORM

(Include a photo of child)

FACILITY

NAME OF FACILITY _____

DATE OF ENROLLMENT YYYY / MM / DD _____

CHILD

NAME OF CHILD _____

SURNAME _____

GIVEN _____

MIDDLE NAME _____

NAME CHILD RESPONDS TO _____

GENDER: _____

ADDRESS _____

DATE OF BIRTH YYYY / MM / DD FIRST DAY OF ATTENDANCE YYYY / MM / DD END DATE YYYY / MM / DD _____

PARENT/GUARDIAN

NAME _____

PLACE OF WORK _____

PHONE _____

LOCAL _____

HOME ADDRESS _____

PHONE _____

HOURS OF WORK _____

POSTAL CODE _____

E-MAIL ADDRESS _____

NAME _____

PLACE OF WORK _____

PHONE _____

LOCAL _____

HOME ADDRESS _____

PHONE _____

HOURS OF WORK _____

POSTAL CODE _____

E-MAIL ADDRESS _____

MEDICAL INFORMATION

FAMILY DOCTOR _____

PHONE _____

MEDICAL INSURANCE PLAN NUMBER _____

DATE EFFECTIVE YYYY / MM / DD _____

ALTERNATE PERSON TO CALL/PICK-UP CHILD IN CASE OF EMERGENCY

NAME _____

RELATIONSHIP _____

PHONE _____

NAME _____

RELATIONSHIP _____

PHONE _____

PERSONS (OTHER THAN PARENT/GUARDIAN AND EMERGENCY CONTACTS) AUTHORIZED TO PICK UP CHILD FROM FACILITY

NAME _____

PHONE _____

NAME _____

PHONE _____

NAME _____

PHONE _____

PERSONS NOT PERMITTED ACCESS TO CHILD

NAME _____

PHONE _____

NAME _____

PHONE _____

ARE THERE CUSTODY ORDERS? _____

YES

NO

IF YES, ATTACH DOCUMENTATION

NAMES OF OTHER CHILDREN LIVING AT HOME

NAME _____

DATE OF BIRTH

YYYY / MM / DD _____

NAME _____

DATE OF BIRTH

YYYY / MM / DD _____

HAS CHILD HAD PREVIOUS EXPERIENCE AWAY FROM HOME? (DAY CARE, PRESCHOOL, SUNDAY SCHOOL, ETC.) YES NO

IF YES, EXPLAIN: _____

WHERE? _____

DATES OF ATTENDANCE: _____

DO YOU THINK YOUR CHILD FEELS COMFORTABLE LEAVING PARENTS? YES NO

EXPLAIN: _____

DOES THIS CHILD HAVE ANY KNOWN HEALTH PROBLEMS/MEDICAL DISABILITIES? YES NO
 IF YES, ATTACH DOCUMENTATION

LIST ANY COMMUNICABLE DISEASES CHILD HAS HAD: _____

HAS HE/SHE HAD ANY RECENT ILLNESS? YES NO IF YES, EXPLAIN: _____

ANY ALLERGIES? YES NO IF YES, PLEASE LIST: _____

IF YES, ATTACH SPECIAL INSTRUCTIONS TO FOLLOW IN THE EVENT OF AN ALLERGIC REACTION

WHAT IS THE CHILD'S EATING HABIT? _____

FAVORITE FOODS: _____

STRONG DISLIKES: _____

BASIC SCHEDULE AND RECORD OF IMMUNIZATION AS SUBMITTED BY PARENT/GUARDIAN
 (ATTACH IMMUNIZATION RECORD - OR RECORD THE DATES)

First Visit – two months of age: YYYY / MM / DD	Fourth Visit – 12 months of age: YYYY / MM / DD
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Measles
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Meningococcal C Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Pneumococcal Conjugate	Fifth Visit – 12 months after third visit: YYYY / MM / DD
<input type="checkbox"/> Meningococcal C Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Second Visit – two months after first visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Haemophilus Influenza Type b (hib)
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Measles, Mumps, Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Pneumococcal Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	
<input type="checkbox"/> Hepatitis B	4 to 6 years of age: YYYY / MM / DD
<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Third Visit – two months after second visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Polio	Other Immunizations:
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	YYYY / MM / DD
<input type="checkbox"/> Hepatitis B	YYYY / MM / DD
<input type="checkbox"/> Pneumococcal Conjugate	YYYY / MM / DD

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:

I HEREBY GIVE MY CONSENT FOR A STAFF MEMBER TO CALL A MEDICAL PRACTITIONER OR AMBULANCE FOR MY CHILD IN THE CASE OF ACCIDENT OR ILLNESS, IF I CANNOT IMMEDIATELY BE REACHED.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

CAREGIVER SIGNATURE _____

DATE _____