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 SEX: ☐ M ☐ F

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