REGISTRATION FORM

CHILD'S INFORMATION

Child's Full Name: _____ Birth Date: _____/_____/_____

Address: _____ Home Phone: _____

City: _____ Prov. /State: _____PC/Zip Code: _____

Nickname: _____

PARENT/GUARDIAN INFORMATION

Mother's Full Name: _____ Home Phone: _____
Address: _____
City: _____ Prov. /State: _____PC/Zip Code: _____
Occupation: _____ Work Phone: _____ext._____
Name of Employer_____ Pager or Cellular Phone: _____
Business Address: _____ City: _____
Work Hours: _____ Driver's License # _____

Father's Full Name: _____ Home Phone: _____
Address: _____
City: _____ Prov. /State: _____PC/Zip Code: _____
Occupation: _____ Work Phone: _____ext._____
Name of Employer_____ Pager or Cellular Phone: _____
Business Address: _____ City: _____
Work Hours: _____ Driver's License # _____

Parent/Guardian with legal custody _____
Parents are: Married ___ Living Together___ Divorced ___ Separated ___ Widowed ___ Single ___

Other Household Members:
Names: _____ Ages: _____ Relationships _____
Names: _____ Ages: _____ Relationships _____
Names: _____ Ages: _____ Relationships _____

CHILD PICK-UP INFORMATION

Please list below the people who have ***Permission*** to pick up your child.
***Note: Anyone picking up your child must have picture ID.**

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Please list those persons who ***Do Not Have Permission*** to pick up your child.
Please explain the reason below or talk to your caregiver so she is aware of the situation.

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Reason person is not allowed to pick up your child:
Name: _____
Reason: _____

Name: _____
Reason: _____

EMERGENCY CONTACTS

Primary Emergency Contact (other than parents or guardian)
Name: _____
Home Phone: _____ Work Phone: _____
Relationship to Child: _____
Address:_____

Secondary Emergency Contact (other than parents or guardian)
Name:_____
Home Phone: _____ Work Phone: _____
Relationship to Child: _____
Address:_____

Any Special Instructions on how to reach parents:
_____
_____
_____

EMERGENCY INFORMATION

1. Child's Physician: _____ Phone: _____

2. Preferred Hospital: _____ Phone: _____

3. Child's Dentist: _____ Phone: _____

3. Insurance Company: _____ Policy #: _____

4. Regular Medications: _____

5. Blood Type: _____

6. Medicine allergic to: _____

7. Food Allergies: _____

8. Any other Allergies: _____

9. Immunization Record: Date of Last Immunization:_____

10. Any special health conditions:

_____

_____

_____

11. **Child has had:**

[ ] Measles
[ ] German Measles
[ ] Chicken Pox
[ ] Mumps
[ ] Whopping Cough
[ ] Other _____

Child suffers from:

[ ] Headaches
[ ] Earaches
[ ] Sore Throat
[ ] Stomach Aches
[ ] Flu / Colds
[ ] Other _____

IMMUNIZATION RECORD

DPT **1.** ___/___/___ **2.** ___/___/___ **3.** ___/___/___ **4.** ___/___/___ 5. ___/___/___

Polio **1.** ___/___/___ **2.** ___/___/___ **3.** ___/___/___ **4.** ___/___/___ **5.** ___/___/___

MMR ___/___/___ Measles ___/___/___ Mumps ___/___/___

Rubella ___/___/___ TB ___/___/___ HIV ___/___/___ HIB ___/___/___

OTHER IMPORTANT INFORMATION/PROVISIONS

Do you have any outstanding concerns?_____
_____
_____
_____
_____