Enrollment Packet

CHILD CARE PROGRAM	
Childcare Program Name:	
Address:	City/State/Zip:

CHILD'S INFORMATION	
Child's Full Name:	Child Resides with:
Nickname:	☐ Mother ☐ Father ☐ Other:
Date of Birth:	Child's Age:
Child's Home Address:	City/State/Zip:

OTHERS AUTHORIZED TO PICK UP CHILD FROM HOME CHILD CARE PROGRAM. ANY CHANGES TO THIS LIST MUST BE MADE IN WRITING.

Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Telephone:	Telephone number:
Relationship to child:	Relationship to child:

PARENT(S)/GUARDIAN(S) INFORMATION	
Mother/Guardian	
Name:	
Home Address:	
City/State/Zip:	
Home Telephone:	
Cell Phone:	
Father/Guardian	
Name:	
Home Address:	
City/State/Zip:	
Home Telephone:	
Cell Phone:	

PARENT(S)/GUARDIAN(S) WORK INFORMATION	
Mother/Guardian Employer	
Company:	Work Telephone:

Work Address:	City/State/Zip:
Father/Guardian Employer	
Company:	Work Telephone:
Work Address:	City/State/Zip:
SPECIAL INSTRUCTIONS TO CONTACT PARENT(S)/GUARDIAN(S):	

OTHER EMERGENCY CONTACT INFORMATION

In case of illness or other emergency, provide the name, address, and telephone number of the nearest relative or friend who can be contacted if the parent cannot be reached.

Name:				
Relationship to Child:	☐ Sister/Brother	☐ Grandparents	☐ Aunt/Uncle	☐ Friend
Address:			Telephone:	
City/State/Zip:				

CHILD'S PEDIATRICIAN OR SOURCE OF HEALTH CARE		
Name of Physician:		Telephone Number:
Address:		
City/State/Zip:		
INSURANCE INFORMATION:		
Policy Holder Name:	Policy Number:	

MEDICAL EMERGENCY STATEMENT

I hereby give ____________________________________ (name of child care provider) permission to have my child,

____ (child's name) transported to the ☐ nearest hospital or ☐

____________________________________ (preferred hospital) for medical treatment when I cannot be reached.

PERMISSION TO TAKE THE CHILD OFF THE PREMISES

I hereby give ___________________________________ (name of child care provider) permission to take my child,

____ (child's name) on excursions from the home child care that

might include the following types of activities:

____

____

____

(The provider should fill in the above list with activities that will be provided away from the home. In addition, provider shall notify parent(s) in advance of any excursions. Examples might include trips to the store, riding in the car, swimming, park, etc.)

_______________________________________ _______________

Parent/Guardian Signature Date

CHILD'S SCHEDULE AND INTEREST – The following information will help provider to better understand and care for you child.

Please describe your child's eating habits, i.e. food they like and dislike, etc.
Describe the play activities that your child likes, both indoors and out-of-doors.
Describe your child's naptime habits.
Describe your child's toilet and hygiene habits.

Please add any other special information that is important to your child's care here:
Does your child have any known allergies? ☐ Yes ☐ No If yes, please explain:
Do your child have any known medical problems? ☐ Yes ☐ No If yes, explain:

Please read the statement below and initial the box that applies to your child and sign and date.

Initial here	My child has known allergies and/or other medical problems. I have requested from my provider and completed a **MEDICAL CARE AND EMERGECY CONTACT INFORMATION** form in order to provide this detailed information. Parent/Guardian Signature Date
Initial here	My child DOES NOT have known allergies and/or other medical problems. Parent/Guardian Signature Date

MEDICAL CARE AND EMERGENCY CONTACT INFORMATION

Child's Name: ____________________ Birth Date: ____________

Address: ____________________

Mother's Name: ____________________ Father's Name: ____________________

Phone (Home): ____________________ Phone (Home): ____________________

Phone (Work): ____________________ Phone (Work): ____________________

Alternate Emergency contact 1: ____________________ Phone: ____________

Alternate Emergency contact 2: ____________________ Phone: ____________

Child's Physician: ____________________ Phone: ____________

Known Allergies of Child (medicine, food, etc.) ____________________

____

Describe past serious illnesses or hospitalization and dates: ____________________

____

Medicines take by child: ____________________

Date of last tetanus injection: ____________________

Describe all physical conditions or illnesses, which could affect the child's participation in the program or proper medical treatment (diabetes, epilepsy, poor blood clotting, etc.):

____

____

Health Insurance: Company ____________________ Policy Number ____________

NOTARIZED EMERGENCY MEDICAL TREATMENT CONSENT

I hereby give ______________________________________ (name of provider) permission to provide first aid care for my child, ____ (name of child). In the event I cannot be reached, I hereby authorize an Ambulance Service to transport my child to the emergency room of the hospital(s) listed below, and I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary. If I have not specified any hospital(s) below, my child may be taken to and cared for at the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred.

Preferred Hospital: ____________________ ☐ Nearest Hospital

Parent/Guardian: ____________________ Date: ____________

Parent/Guardian: ____________________ Date: ____________

State of: ____________________ County of: ____________________

The foregoing Consent was acknowledged before me this ________ day of _______, 20____, by

____ and ____.

(Notary Seal) Notary Public My Commission Expires: