

REGISTRATION PACKET

DATE: _____

Child's Name: _____

Nickname: _____

Home Address: _____

Home Phone: _____ Sex: M F Age: _____ Date of Birth: _____

Family Members: _____

Mother or Guardian's Name: _____

Address if different from child: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Name of Employment (Mother/Guardian): _____

Address of Employment: _____

Work Phone: _____

Father or Guardian's Name: _____

Address if different from child: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Name of Employment (Father/Guardian): _____

Address of Employment: _____ Work Phone: _____

Special instructions for reaching parent or guardian:

School: _____ Grade: _____

Emergency Contacts and Authorization for Treatment & Transportation:

First point of contact is both of the parents or guardians. THEN you give authorization to call the following:

Name: _____

Best Phone: _____

Address: _____

Work Phone: _____ Relationship to child: _____

Name: _____

Best Phone: _____

Address: _____

Work Phone: _____ Relationship to child: _____

HEALTH RECORD

Food Allergies: _____

Other Allergies: _____

Chronic Medical Conditions: _____

Immunization is not a requirement to enroll in Day Care we highly recommend your child be fully protected and subsequently protect the other children and staff from communicable diseases.

Is your child **fully immunized**? _____

Is there a reason your child is not fully immunized? _____

Is your child on any medications? _____

Physical Limitations: _____

Dietary Limitations: _____

Insurance Provider: _____ ID: _____

PHONE of Insurance Provider: _____

Are there any activities that you prefer your child NOT participate in? _____

Child's Physician Name: _____

Address: _____ PHONE: _____

Dentist Name: _____

Address: _____ PHONE: _____

Unless a parent/guardian specifies otherwise – All children will be taken to the closest Hospital:

- ST THOMAS MORE HOSPITAL
1338 Phay Ave
Canon City CO 81212
719-285-2000

I hereby give permission to PROSPECTORS KID'S CLUB personale or any other individual to call a doctor or emergency medical service or ambulance to provide emergency medical or surgical care for my child _____ (initials).

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians, emergency contacts listed on this form before any action will be taken. If it is not possible to locate emergency contacts treatment will NOT be delayed.

I /we will accept the financial expense of any emergency transportation, medical or surgical treatment incurred. I/we will hold the caregivers harmless of any wrongdoing whatsoever in the effort to provide prompt medical care to my child.

Parent/Guardian Signatures:

Name printed

Signature Date

Name printed

Signature Date

CHILD PICKUP INFORMATION

Persons authorized to pick up your child (**Must show photo ID**)

Name: _____

Best Phone: _____

Name: _____

Best Phone: _____

Name: _____

Best Phone: _____

Secret Code to be given by people who need to pick up your child who are not registered (in case of emergency) (optional): _____

A Copy of Court Orders required to be on file at the Day Care Center in the event of a restriction on parental rights; otherwise a parent has the right to pick up a child at any time.

Anyone forbidden to see, speak to or pick up your child? _____

Restraining Order on record with courts? _____

Copy of Court Orders Attached? _____ (initial).