PARENT/GUARDIAN & CHILD INFORMATION SHEET

GENERAL INFORMATION (Last, First)

Parent/Guardian's Name:		**Relationship to Child:**	
Home Address:	City:	State:	Zip code:
CELL Phone Number:	Email Address:		
HOME Phone Number:	Work/School Name:	Work Phone Number:	
Work/School Address:	City:	State:	Zip code:

Parent/Guardian's Name:		**Relationship to Child:**	
Home Address: □ Check if Same Address	City:	State:	Zip code:
CELL Phone Number:	Email Address:		
HOME Phone Number:	Work/School Name:	Work Phone Number:	
Work/School Address:	City:	State:	Zip code:

CHILDREN INFORMATION

Child's Name:	**Date of Birth:**	***Does your child have: (check all that apply, explain if Yes)***
Allergies □ NO □ YES:	Dietary Restriction □ NO □ YES:	
Medications (Epi Pen or Inhaler) □ NO □ YES:	Medical Condition □ NO □ YES:	
Any other medical or special need that we need to be aware of □ No □ Yes:		
Permission to rest on Mat: □ Yes □ No	Permission to watch Movie: □ Yes □ No	Permission to watch PG Movies: □ Yes □ No

Child's Name:	**Date of Birth:**	***Does your child have: (check all that apply, explain if Yes)***
Allergies □ No □ Yes:	Dietary Restriction □ No □ Yes:	
Medications (Epi Pen or Inhaler) □ No □ Yes:	Medical Condition □ No □ Yes:	
Any other medical or special need that we need to be aware of □ No □ Yes:		
Permission to rest on Mat: □ Yes □ No	Permission to watch Movie: □ Yes □ No	Permission to watch PG Movies: □ Yes □ No

Child's Name:	**Date of Birth:**	***Does your child have: (check all that apply, explain if Yes)***
Allergies □ No □ Yes:	Dietary Restriction □ No □ Yes:	
Medications (Epi Pen or Inhaler) □ No □ Yes:	Medical Condition □ No □ Yes:	
Any other medical or special need that we need to be aware of □ No □ Yes:		
Permission to rest on Mat: □ Yes □ No	Permission to watch Movie: □ Yes □ No	Permission to watch PG Movies: □ Yes □ No

Child's Name:	**Date of Birth:**	***Does your child have: (check all that apply, explain if Yes)***
Allergies □ No □ Yes:	Dietary Restriction □ No □ Yes:	
Medications (Epi Pen or Inhaler) □ No □ Yes:	Medical Condition □ No □ Yes:	
Any other medical or special need that we need to be aware of □ No □ Yes:		
Permission to rest on Mat: □ Yes □ No	Permission to watch Movie: □ Yes □ No	Permission to watch PG Movies: □ Yes □ No

MEDICAL & DENTAL INFORMATION

Insurance Carrier:	**Policy Number:**		
Physician Office:	Phone Number:		
Address:	City	State:	Zip code:
Hospital of Choice	Phone Number:		
Address:	City:	State:	Zip code:
Dentist Office:	Phone Number:		
Address:	City:	State:	Zip code:

EMERGENCY CONTACTS (PERSONS ALLOWED TO PICK UP) Code Word:

***Please list the name of <u>at least one person</u> who can be contacted in the event of emergency or illness if you cannot be reached. These contacts must be able to take responsibility for the children if you cannot be contacted. All emergency contacts must be 18 years of age and provide Valid ID and Code Word to pick up.**

Name:	**Relationship to Child(ren):**	
Home Address:	City:	Zip code:
Telephone Number	Is this person okay to pick up anytime?	□ **Yes** □ **No**
Name:	**Relationship to Child(ren):**	
Home Address:	City:	Zip code:
Telephone Number	Is this person okay to pick up anytime?	□ **Yes** □ **No**
Name:	**Relationship to Child(ren):**	
Home Address:	City:	Zip code:
Telephone Number	Is this person okay to pick up anytime?	□ **Yes** □ **No**
Name:	**Relationship to Child(ren):**	
Home Address:	City:	Zip code:
Telephone Number	Is this person okay to pick up anytime?	□ **Yes** □ **No**

Photo and Media Release

I hereby grant permission to KidsTown and any other contractors or medial representatives used in promoting the center to photograph my child(ren). It is my understanding that this photograph/interview or portions thereof will be used for public view. I agree to participate in this project without financial remuneration, and I understand that this releases photographer/interviewer from any future claims, as well as any liability arising from the use of said photograph/interview.

□ **YES** □ **NO**	Parent Signature:	Date:

Hourly Licensing Limits

KidsTown is an hourly based drop-in childcare center licensed through the State of Colorado; therefore, it is a state requirement that our license permits each child to stay at the center for a maximum of six (6) hours per day not to exceed fifteen (15) hours per week.
Families that exceed the center's licensing requirement of six (6) hours per day will be provided a written warning that will be signed and kept in the family's file. Families that receive more than four (4) written warnings in a 30-day calendar month will be suspended for 30 days.

Payment/Packages

Payment for childcare, food and registration fees are due in full upon services rendered. All payments made for registration fees, food, packages etc. are not refundable regardless of reason or circumstance. All Packages will expire ONE year from date of purchase. All rates are rounded to the nearest quarter for ease and to eliminate financial errors. Package hours may be used at any time except during special promotions
Packages are non-refundable. Unused package balances will NOT be refunded regardless of circumstance
Please note once the center closes, there is $1.00 Penalty for every minute you are late. Fees will be collected at the time of pickup in CASH only

I GIVE MY CONSENT FOR THE CHILDREN LISTED ON THIS FORM TO RECEIVE EMERGENCY MEDICAL OR DENTAL TREATMENT IN THE CARE OF A PHYSICIAN AND/OR HOSPITAL OR CLINIC. I HAVE RECEIVED THE CENTER'S POLICIES AND PROCEDURES AND WILL REVIEW THEM THOROUGHLY SO THAT I MAY UNDERSTAND THE RIGHTS AND PROTECTION OF MY CHILDREN. I HAVE READ THE HOURLY LICENSING LIMIT PROCEDURES AND PENALTIES THAT ARE REQUIRED BY THE STATE OF COLORADO. I UNDERSTAND THAT ALL PACKAGE PURCHASES ARE NON-REFUNDABLE AND EXPIRE ONE YEAR AFTER DATE OF PURCHASE.

Date of Enrollment:	**Parent Signature:**

SIGNATURES REQUIRED UPON YEARLY REVIEW – DO <u>NOT SIGN UPON ENROLLMENT</u>

Date of One Year Review:	**Parent Signature:**
Date of Second Year Review:	**Parent Signature:**
Date of Third Year Review:	**Parent Signature:**