

## Family Child Care Registration Form

Date of Enrollment: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_ Sex: M\_\_ F\_\_

Health #: \_\_\_\_\_ ID#: \_\_\_\_\_  
Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Full name of Mother: \_\_\_\_\_

Full name of Father: \_\_\_\_\_

Mother's Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Place of work: \_\_\_\_\_ Hours: \_\_\_\_\_

Father's Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Place of work: \_\_\_\_\_ Hours: \_\_\_\_\_

Person(s) to contact incase of emergency/Authorized to pick up child:

1. Name: _____	2. Name: _____
Relationship to child: _____	Relationship to child: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____

Other Person(s) Authorized to pick up child:

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

Names of other children in family:

Name: _____	Birthdate: __/__/__
Name: _____	Birthdate: __/__/__
Name: _____	Birthdate: __/__/__

Has child had previous experience away from home? Yes ( ) No ( ) If yes explain:

\_\_\_\_\_  
\_\_\_\_\_

Are your Child's immunizations up to date? Yes ( ) No ( )

If no please explain: \_\_\_\_\_

\_\_\_\_\_

**Note: attach a copy of immunization record**

## Child's Health History

Does child have any known health problems? Yes ( ) No ( ) (If yes attach documentation)

Check (✓) any of the following illnesses the child has had:

- Asthma    Earaches    Mumps    Whooping Cough    Bronchitis  
Eczema    Pneumonia    Polio    Chicken Pox    Frequent Colds  
Croup    Convulsions    Measles    Influenza    Rheumatic Fever  
Diphtheria    Tonsillitis    Tonsillitis    Other:\_\_\_\_\_

Please list any injuries child has had:\_\_\_\_\_

Does your child have any know allergies? Yes ( ) No ( ) If yes, what are they and what are your child's reactions:\_\_\_\_\_

Does your child take any medication on a regular basis? Yes ( ) No ( ) If yes please list the name of the medication(s) and the medical condition for which it is taken:

\_\_\_\_\_

Do you have any concerns about your child's development? Yes ( ) No ( ) If yes please comment: \_\_\_\_\_

\_\_\_\_\_

Please comment on any other medical information/ or special need the child care provider should be aware of: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SPECIAL TRANSPORTATION ARRANGEMENTS:

CCD requires a written plan of the transportation arrangements between the child care facility and the parent or guardian of the child for extracurricular activities. The following indicates the child care facility's transportation plan:

\_\_\_\_\_ (child) attends \_\_\_\_\_ (school). He/she will be transported/escorted between the child care facility and the school by (check applicable type): \_\_\_\_\_ school bus, \_\_\_\_\_ (childcare facility) or \_\_\_\_\_ will arrive/ depart unescorted with my permission. If my child is not at the designated pickup site, or does not arrive as planned, please contact (check applicable type):

\_\_\_\_\_ (parent/guardian) or \_\_\_\_\_ (the school), in order to confirm the child's whereabouts, as well as devise a plan as needed to locate the child. My child also has permission to (**specify**, ie: work with teacher after school, attend an extracurricular class or meeting, depart for home at specific time, etc.)

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In the event the child(ren) named above is injured or ill, I understand the caregiver will attempt to reach the parent(s) or guardian(s) at the phone numbers listed above. In the event no one can be reached, I give my permission for the caregiver to provide first aid for the child named above or take appropriate measures, including contacting EMS for transport to \_\_\_\_\_ or the nearest medical facility. The undersigned parent/guardian of the minor(s) listed above authorize the family doctor, pediatrician or Emergency Room physician in charge to act in my behalf to consent to all necessary and appropriate medical treatment, surgery, or hospital care which is advisable under the general care of a licensed physician or surgeon under the laws of the State of Oregon or Washington. I assume all financial responsibility for such care.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of parent/guardian)

# A Place To Grow Daycare

## Parent/ Guardian Authorization

Please list any restrictions to permission of the following:

- € My child may be taken on field trips or excursions by private motor vehicle, as well as on neighborhood walking excursions under required supervision.
  
- € My child may participate in swimming or other water activities under required supervision
  
- € My child may be given non-prescribed medication as indicated on the container. This may include sunscreen, children's pain reliever, antibacterial first aid cream, and diaper ointment. Syrup of ipecac may be administered if deemed necessary by the poison control operator. The child's parent or guardian will be contacted prior to administering non-prescription pain relievers. Prescription medications must be current and a permission slip is required for each medication.
  
- € My child may be photographed for publicity or news purposes
  
- € On-site
- € Off-site

**In an emergency**, the child care facility has my permission to call an ambulance, or take my child to any available physician or hospital at my expense to obtain medical treatment.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

# **A Place To Grow Daycare**

## **Medical Treatment Authorization**

I give Margaret Trueb permission to obtain emergency medical/dental treatment for my child,  
\_\_\_\_\_.

I also give permission for my child to be transferred by ambulance in cases of medical necessity.

Child's Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Medical Plan: \_\_\_\_\_

Number: \_\_\_\_\_

Parent's Address: \_\_\_\_\_

City: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Other Phone Number: \_\_\_\_\_

Parent/ Guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_