FOR OFFICE USE ONLY

Program _____

Best Friends for Kidz
Child's Enrollment/Information Form

CHILD'S NAME: _____ PREFERRED NAME: _____

DOB: _____ DATE ENROLLED: _____

ADDRESS: _____ ZIP CODE: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

EMAIL: _____

CUSTODIAL PARENT (CIRCLE ONE): MOTHER FATHER JOINT

HOME/CELL PHONE: _____ HOME/CELL PHONE: _____

Cell phone provider: _____ Cell phone provider: _____

WORK PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ EMPLOYER: _____

LEGAL GUARDIAN NAME (if different than above): _____

PERSONS AUTHORIZED TO REMOVE CHILD (LEGAL IDENTIFICATION REQUIRED)

1. _____
   NAME RELATIONSHIP PHONE

2. _____
   NAME RELATIONSHIP PHONE

ALTERNATE NUTRITION PLAN AGREEMENT

I understand and approve the use of the Alternate Nutrition Plan. I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs.

Indicate any Special Dietary Requirements:

_____

_____

(Mark "P" for Parent Provides, or "C" for Center Provides)

Breakfast	A.M. Snack	Noon Meal	P.M. Snack	Dinner	Evening Snack	Formula

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HILLSBOROUGH COUNTY ORDINANCE requires that parents must receive a copy of the "KNOW YOUR CHILD CARE FACILITY/FCCH BROCHURE", information on the INFLUENZA (FLU) VIRUS, and the parents are notified in writing of the "DISCIPLINARY PRACTICES" used by the Child Care Facility/FCCH. The parent's/ legal guardian's signature certifies receipt of the Child Care Facility/FCCH brochure, influenza information, discipline policies, alternate nutrition plan agreement and that all the information on this form is complete and accurate.

_____ _____

Signature of Parent or Legal Guardian Date

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Medical Alert Information (i.e., allergies, medical and/or special needs/conditions): _____

_____

List any additional information which would be beneficial for the child care provider to know about your child: _____

_____

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Hospital: _____

NOTE: Physical & Immunization Record should accompany child.

EMERGENCY CONTACT (OTHER THAN PARENTS):

1. _____
NAME RELATIONSHIP PHONE

2. _____
NAME RELATIONSHIP PHONE

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, should become ill or
CHILD'S FULL NAME

Injured at, _____, I understand that the
NAME OF FACILITY/PROVIDER

Child Care Provider will: (1) Contact me immediately and (2) Contact the person (s) I have designated if I cannot be reached.

Should the provider be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

_____
SIGNATURE RELATIONSHIP DATE

(OPTIONAL)

Sworn to and subscribed before me this _____, day of _____, 20_____.

_____
Notary Public, State of Florida – At Large.

My Commission Expires: _____

_____ who is/are personally known to me

_____ who has/have produced identification: _____