

Little Sprouts Learning Center ~ Registration Form

Date of Tour: _____ Date of Enrollment: _____ Registration Paid: _____

Name of Child: _____ Birthdate: __/__/__ Sex: M__ F__

Full name of Mother: _____

Full name of Father: _____

Mother's Address: _____

Home#: _____ Work#: _____ Cell#: _____

Place of work: _____

Hours: _____

Email address: _____

Father's Address: _____

Home#: _____ Work#: _____ Cell#: _____

Place of work: _____

Hours: _____

Email address: _____

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

1. Name: _____ 2. Name: _____

Relationship: _____ Relationship: _____

Home#: _____ Home#: _____

Work#: _____ Work#: _____

Cell#: _____ Cell#: _____

Other Person(s) Authorized to pick up child:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ 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: _____

Child's Doctor: _____

Phone#: _____

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 ☐Croup
☐Frequent Cold ☐Convulsions ☐Measles ☐Influenza
☐Rheumatic Fever ☐Diphtheria ☐Tonsillitis ☐Other:_____

Please list any injuries child has had:_____

Does you 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: _____

I authorize the child care provider/staff to obtain the following services for this child if necessary: Public Health Nurse, Physician and or Ambulance in the event of an emergency. (ambulance fees and/or health care costs are the responsibility of the parent/guardian)

(Date)

(Signature of parent/guardian)

(Signature of child care provider)

(Signature of parent/guardian)