CHILD CARE REGISTRATION FORM

(Include a photo of child). **Days Booking _____**

FACILITY

NAME OF FACILITY DATE OF ENROLLMENT
YYYY / MM / DD

CHILD

NAME OF CHILD
SURNAME GIVEN MIDDLE NAME

NAME CHILD RESPONDS TO SEX: ? M ? F
ADDRESS

Email Address:

DATE OF BIRTH YYYY / MM / DD FIRST DAY OF ATTENDANCE YYYY / MM / DD
END DATE YYYY / MM / DD

PARENT/GUARDIAN

NAME
PLACE OF WORK PHONE LOCAL
HOME ADDRESS PHONE HOURS OF WORK
NAME
PLACE OF WORK PHONE LOCAL
HOME ADDRESS PHONE HOURS OF WORK

MEDICAL INFORMATION

FAMILY DOCTOR(if don't have one list 911 or local medical clinic info)
PHONE
MEDICAL INSURANCE PLAN NUMBER(BCMSP#): DATE EFFECTIVE
YYYY / MM / DD

ALTERNATE PERSON TO CALL/PICK-UP CHILD IN CASE OF EMERGENCY

NAME RELATIONSHIP
PHONE
NAME RELATIONSHIP
PHONE

PERSONS (OTHER THAN PARENT/GUARDIAN AND EMERGENCY CONTACTS) AUTHORIZED TO PICK UP CHILD FROM FACILITY

NAME PHONE
NAME PHONE
NAME PHONE

PERSONS NOT PERMITTED ACCESS TO CHILD

NAME PHONE
NAME PHONE

ARE THERE CUSTODY ORDERS? ? YES ? NO IF YES, ATTACH DOCUMENTATION

NAMES OF OTHER CHILDREN LIVING AT HOME

NAME DATE OF BIRTH YYYY / MM / DD

NAME DATE OF BIRTH YYYY / MM / DD

HAS CHILD HAD PREVIOUS EXPERIENCE AWAY FROM HOME? (DAY CARE, PRESCHOOL, SUNDAY SCHOOL, ETC.)

? YES ? NO

IF YES, EXPLAIN:

_____

WHERE? _____DATES OF ATTENDANCE: _____

DO YOU THINK YOUR CHILD FEELS COMFORTABLE LEAVING PARENTS? ? YES ? NO

EXPLAIN:

_____

DOES THIS CHILD HAVE ANY KNOWN HEALTH PROBLEMS/MEDICAL DISABILITIES? ? YES ? NO

IF YES, ATTACH DOCUMENTATION

LIST ANY COMMUNICABLE DISEASES CHILD HAS HAD:

_____

HAS HE/SHE HAD ANY RECENT ILLNESS? ? YES ? NO IF YES, EXPLAIN: _____

ANY ALLERGIES? ? YES ? NO IF YES, PLEASE LIST:

_____

IF YES, ATTACH SPECIAL INSTRUCTIONS TO FOLLOW IN THE EVENT OF AN ALLERGIC REACTION

WHAT IS THE CHILD'S EATING HABIT?

_____

FAVORITE FOODS:

_____

STRONG DISLIKES:

_____

BASIC SCHEDULE AND RECORD OF IMMUNIZATION AS SUBMITTED BY PARENT/GUARDIAN

(ATTACH IMMUNIZATION RECORD - OR RECORD THE DATES

First Visit – two months of age: YYYY / MM / DD	Fourth Visit – 12 months of age: YYYY / MM / DD
Diphtheria	**Measles**
Pertussis	**Mumps**
Tetanus	**Rubella**
Polio	**Meningococcal C Conjugate**
Haemophilus Influenza Type b (hib)	**Varicella (chicken pox)**
Hepatitis B	
Pneumococcal Conjugate	Fifth Visit – 12 months after third visit: YYYY / MM / DD
Meningococcal C Conjugate	**Diphtheria**
	Pertussis
Second Visit – two months after first visit: YYYY / MM / DD	**Tetanus**
Diphtheria	**Polio**
Pertussis	**Haemophilus Influenza Type b (hib)**
Tetanus	**Measles, Mumps, Rubella**
Polio	**Pneumococcal Conjugate**
Haemophilus Influenza Type b (hib)	

Hepatitis B	4 to 6 years of age: *YY*YY / MM / DD
Pneumococcal Conjugate	**Diphtheria**
	Pertussis
Third Visit – two months after second visit: YYYY / MM / DD	**Tetanus**
Diphtheria	**Polio**
Pertussis	**Varicella (chicken pox)**
Tetanus	
Polio	Other Immunizations:
Haemophilus Influenza Type b (hib)	YYYY / MM / DD
Hepatitis B	YYYY / MM / DD
Pneumococcal Conjugate	YYYY / MM / DD

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:

I HEREBY GIVE MY CONSENT FOR A STAFF MEMBER TO CALL A MEDICAL PRACTITIONER OR AMBULANCE FOR MY CHILD IN THE CASE OF ACCIDENT OR ILLNESS, IF I CANNOT IMMEDIATELY BE REACHED.

PARENT/GUARDIAN SIGNATURE

_____

DATE

_____

CAREGIVER SIGNATURE

_____

DATE

_____

Email address: _____