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 PHONE

MEDICAL INSURANCE PLAN NUMBER 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: *Y*YYY / 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**