CHILD ENROLLMENT & EMERGENCY MEDICAL CARE FORM

Date of Application: **Date of Enrollment:** **Last Day of Enrollment:**
Child's Name: Child's Date of Birth:
Child's Address: City: Zip Code
Mother's Name: Address:
City: Zip Code: e-mail Address:
Home Telephone #: ( ) Cell #: ( )
Mother's Employer: Work #: ( )
Mother's Employer Address: City: Zip Code
Father's Name: Address:
City: Zip Code: e-mail Address:
Home Telephone #: ( ) Cell #: ( )
Father's Employer: Work #: ( )
Father's Employer Address: City: Zip Code

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Weekly Care Schedule: (please include the child's hours in care for each day)

Sunday:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:

Persons permitted to remove the child from the child care program on behalf of parent. (Use back for additional names.)

Name:
Phone #: Relationship

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In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.

(Use back for additional names.)

Name:
Phone #: Relationship

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Medical Information

Known Allergies: Last Tetanus:
Insurance Carrier: Insurance ID:

Child's Physician: Name: Phone #: ( )
Address City: Zip Code:
Child's Dentist: Name: Phone #: ( )
Address City: Zip Code:

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Emergency Authorization

I give my consent for the First Aid and CPR certified staff of **(program's name)** , to administer first aid and CPR to my child and to contact the above named physician or dentist if my child has a medical emergency. I also give my consent for my child to be transported to the nearest hospital in the event of a medical emergency. I will be responsible for all medical fees.

Preferred Medical Facility:

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Behavior Management and Parent Handbook

I acknowledge that I have read the parent handbook and agree to abide by the policies contained in it and that the techniques used to manage child behaviors in the facility have been discussed with me prior to enrollment.

Signature of Parent or Guardian: **Date**:

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