

Child Registration
Please complete and return this page

Parent or Guardian:	Parent or Guardian:
Address:	Address if different:
City, State, Zip	City, State, Zip
Home Phone:	Home Phone:
Cell:	Cell:
Employer:	Employer:
Department:	Department:
Work Phone:	Work Phone:
E-mail address:	E-mail address:
Child Name:	Preferred Name: Date of Birth: Sex:M/F
Child Name:	Preferred Name: Date of Birth: Sex:M/F
Child Name:	Preferred Name: Date of Birth: Sex:M/F
Family Doctor:	Phone:

Emergency Surgical/Medical Care:

I give my permission to obtain emergency surgical/medical care.

I hereby certify that to the best of my knowledge my child does not have an ailment or organic defect which would be dangerous to his/her health and that he/she is able to participate in the routine program. I further certify that to the best of my knowledge my child does not have a communicable disease.

 Parent or Guardian

 Parent or Guardian

Child Demographic Form

Please complete and return this page.

Child's Name: _____ Date of Birth : _____ Sex: Male Female

Child's Ethnicity: _____ (optional)

Current Medical Information:

Allergies to food, medication, insect bites, or other: (allergies/food intolerances must be documented by a physician):

Prescription medicines taken regularly:

Disability/Special needs:

Chronic or recurring illnesses:

Medical History:

Did your child have any medical problems at birth? Yes No

If yes, explain

Has your child had any medical or developmental problems since birth? Yes No

If yes, explain

Personal History:

Is this an adoptive or foster family? Yes No

Are there any legal matters that we need to be aware of? Yes No if yes, please provide to the director.

List all adults and children in the household:

Has your child ever been in a child care/ school? Yes No If yes, duration?

Was it a positive experience for you and your child? Yes No

Does your child use special words for bodily functions and/or body parts?

Does your child have any fears? (Darkness, animals, etc.)?

Is your child toilet trained? Yes No Does your child still have accidents? Yes No Frequency

Does your child usually take naps? Yes No Duration

Please provide any additional information which may be helpful.
