

REGISTRATION FORM

CHILD'S INFORMATION

Child's Full Name: _____ **Birth Date:** ____/____/____

Address: _____ **Home Phone:** _____

City: _____ **Prov. /State:** _____ **PC/Zip Code:** _____

Nickname: _____

PARENT/GUARDIAN INFORMATION

Mother's Full Name: _____ **Home Phone:** _____

Address: _____

City: _____ **Prov. /State:** _____ **PC/Zip Code:** _____

Occupation: _____ **Work Phone:** _____ **ext.** _____

Name of Employer _____ **Pager or Cellular Phone:** _____

Business Address: _____ **City:** _____

Work Hours: _____ **Driver's License #** _____

Father's Full Name: _____ **Home Phone:** _____

Address: _____

City: _____ **Prov. /State:** _____ **PC/Zip Code:** _____

Occupation: _____ **Work Phone:** _____ **ext.** _____

Name of Employer _____ **Pager or Cellular Phone:** _____

Business Address: _____ **City:** _____

Work Hours: _____ **Driver's License #** _____

Parent/Guardian with legal custody _____

Parents are: Married ___ Living Together ___ Divorced ___ Separated ___ Widowed ___ Single ___

Other Household Members:

Names: _____ Ages: _____ Relationships _____

Names: _____ Ages: _____ Relationships _____

Names: _____ Ages: _____ Relationships _____

CHILD PICK-UP INFORMATION

Please list below the people who have ***Permission*** to pick up your child.

***Note: Anyone picking up your child must have picture ID.**

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Please list those persons who ***Do Not Have Permission*** to pick up your child.
Please explain the reason below or talk to your caregiver so she is aware of the situation.

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Reason person is not allowed to pick up your child:

Name: _____
Reason: _____

Name: _____
Reason: _____

EMERGENCY CONTACTS

Primary Emergency Contact (other than parents or guardian)

Name: _____
Home Phone: _____ Work Phone: _____
Relationship to Child: _____
Address: _____

Secondary Emergency Contact (other than parents or guardian)

Name: _____
Home Phone: _____ Work Phone: _____
Relationship to Child: _____
Address: _____

Any Special Instructions on how to reach parents:

EMERGENCY INFORMATION

- 1. Child's Physician: _____ Phone: _____
- 2. Preferred Hospital: _____ Phone: _____
- 3. Child's Dentist: _____ Phone: _____
- 3. Insurance Company: _____ Policy #: _____
- 4. Regular Medications: _____
- 5. Blood Type: _____
- 6. Medicine allergic to: _____
- 7. Food Allergies: _____
- 8. Any other Allergies: _____
- 9. Immunization Record: Date of Last Immunization: _____
- 10. Any special health conditions:

11. Child has had:

- Measles
- German Measles
- Chicken Pox
- Mumps
- Whooping Cough
- Other _____

Child suffers from:

- Headaches
- Earaches
- Sore Throat
- Stomach Aches
- Flu / Colds
- Other _____

IMMUNIZATION RECORD

DPT 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___
Polio 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___
MMR ___/___/___ Measles ___/___/___ Mumps ___/___/___
Rubella ___/___/___ TB ___/___/___ HIV ___/___/___ HIB ___/___/___

OTHER IMPORTANT INFORMATION/PROVISIONS

Do you have any outstanding concerns? _____

