



Child Enrollment Authorization

Child's Name (Last, First)		Child Nickname
Date of Birth	Date Entered Care	Age at Entry
ALLERGY ALERT Does your child have allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list all allergies on back side of form.		
Parent or Guardian Contact Information		
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Home Phone	Cell Phone	Email Address
Employer and Work Hours	Address (Street, City, Zip)	Work Phone
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Home Phone	Cell Phone	Email Address
Employer and Work Hours	Address (Street, City, Zip)	Work Phone
Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Non-Emergency Contact Information – person other than parent or guardian that is authorized to pick up child		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Medical/Dental Contact Information		
Insurance Provider and Policy Information (if applicable)		
Primary Physician Name		Phone
Dental Provider		Phone
Parent or Guardian Authorization		
Please list any restrictions to permission of the following:		
My child may be taken on field trips or excursions by bus or private motor vehicle, as well as on neighborhood walking excursions under required supervision (see special transportation arrangements section on back of form). <input type="checkbox"/> Yes <input type="checkbox"/> No		
My child may participate in swimming (OCC requires approved lifeguard) or other water activities under required supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No		
My child may be photographed for publicity or news purposes <input type="checkbox"/> Yes <input type="checkbox"/> No This applies to <input type="checkbox"/> On-site <input type="checkbox"/> Off-site photography.		
In an emergency, the child care facility has my permission to call an ambulance, or take my child to any available physician or hospital at my expense to obtain medical treatment. In most emergencies, 911 is called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child is notified as soon as possible.		
Parent/Guardian Signature		Date

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Child Information

Has your child previously been in child care? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what type of care and for how long?		
Reason for requesting care		
Child General Information – please include all information that will assist us in providing quality care for your child		
Likes and dislikes		
Eating habits and schedule		
Toileting habits and schedules		
Sleeping habits and Schedule		
Play		
Fears		
How your child like does to be comforted when upset?		
Child's home language		
Special word and their meanings		
Are there family cultural backgrounds, traditions, beliefs, or interests that you would like to share with us?		
Does your child have any educational special needs (IFSP, etc.) No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, List any health partners or providers you would like us to know about.		
Child Medical Information		
Does your child have special medical needs? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, List any health partners or providers you would like us to know about.		
Does your child have allergies No <input type="checkbox"/> Yes <input type="checkbox"/> If, yes list below Has your child had chicken pox No <input type="checkbox"/> Yes <input type="checkbox"/>		
Other Children in the Home		
Name (first, Last)	Age	Gender
Name (first, Last)	Age	Gender
Name (first, Last)	Age	Gender
Name (first, Last)	Age	Gender



Medical Authorization for Non-Prescribed Medications

Child's Name: _____

All over the counter medications including topical substances shall be in the original container and labeled with the child's name. My child may be given non-prescribed medication. This may include the following:

Acetaminophen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotic cream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insect Repellent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip Balm	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antiseptic wipes/gel	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash Ointment/Cream	<input type="checkbox"/> Yes <input type="checkbox"/> No
Baby Lotion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Saline Nose Drops	<input type="checkbox"/> Yes <input type="checkbox"/> No
Baby Oil	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shampoo	<input type="checkbox"/> Yes <input type="checkbox"/> No
Baby Powder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sunburn Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough Syrup	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sunscreen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diapering Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Teething medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diaper Wipes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toothpaste	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hydrocortisone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Petroleum Jelly	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other:

Parent/Guardian's Signature

Date

Parent/Guardian's Printed Name