Child Care Registration Form
(Include a photo of child)

FACILITY
NAME OF FACILITY   DATE OF ENROLLMENT YYYY / MM / DD

CHILD
NAME OF CHILD
SURNAME   GIVEN   MIDDLE NAME

NAME CHILD RESPONDS TO   GENDER:
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 ________________
POSTAL CODE   E-MAIL ADDRESS

NAME
PLACE OF WORK   PHONE   LOCAL
HOME ADDRESS   PHONE   HOURS OF WORK ________________
POSTAL CODE   E-MAIL ADDRESS

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: YYYY / MM / DD
	❑ **Pneumococcal Conjugate**
❑ **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**
❑ **Rotavirus**	❑ **Pertussis**
	❑ **Tetanus**
Second Visit – two months after first visit: YYYY / MM / DD	❑ **Polio**
❑ **Diphtheria**	❑ **Haemophilus Influenza Type b (hib)**
❑ **Pertussis**	
❑ **Tetanus**	4 to 6 years of age: YYYY / MM / DD
❑ **Polio**	❑ **Diphtheria**
❑ **Haemophilus Influenza Type b (hib)**	❑ **Pertussis**
❑ **Hepatitis B**	❑ **Tetanus**
❑ **Pneumococcal Conjugate**	❑ **Polio**
❑ **Rotavirus**	❑ **Varicella (chicken pox)**
Third Visit – two months after second visit: YYYY / MM / DD	❑ **Measles**
❑ **Diphtheria**	❑ **Mumps**
❑ **Pertussis**	❑ **Rubella**
❑ **Tetanus**	Other Immunizations:
❑ **Polio**	❑ **COVID-19 – 1st Dose**
❑ **Haemophilus Influenza Type b (hib)**	❑ **COVID-19 – 2nd Dose**
❑ **Hepatitis B**	❑ **COVID-19 – 3rd Dose**
❑ **Rotavirus**	

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 ____________________