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 _____

Guardian/Mother's Name: _____Address: _____

City: _____ Zip Code: _____e-mail Address: _____

Home Telephone #: Cell #: _____, _____

Mother's Employer: _____ Work #: _____, _____

Mother's Employer Address: _____ City: _____ Zip Code _____

Guardian/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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Persons permitted to remove the child from the childcare program on behalf of parent. (Use for additional names.)

Name: _____ Phone #: _____Relationship _____

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

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 New England Country Day School, 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: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

****** **Please Attach Xerox copies of signed driver's license and insurance cards** ******