

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: _____

PHOTO HERE

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
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Pneumococcal Conjugate
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Measles
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Mumps
<input type="checkbox"/> Polio	<input type="checkbox"/> Rubella
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	<input type="checkbox"/> Meningococcal C Conjugate
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Pneumococcal Conjugate	Fifth Visit – 12 months after third visit: YYYY / MM / DD
<input type="checkbox"/> Meningococcal C Conjugate	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Rotavirus	<input type="checkbox"/> Pertussis
	<input type="checkbox"/> Tetanus
Second Visit – two months after first visit: YYYY / MM / DD	<input type="checkbox"/> Polio
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Haemophilus Influenza Type b (hib)
<input type="checkbox"/> Pertussis	
<input type="checkbox"/> Tetanus	4 to 6 years of age: YYYY / MM / DD
<input type="checkbox"/> Polio	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	<input type="checkbox"/> Pertussis
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Polio
<input type="checkbox"/> Rotavirus	<input type="checkbox"/> Varicella (chicken pox)
Third Visit – two months after second visit: YYYY / MM / DD	<input type="checkbox"/> Measles
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Rubella
<input type="checkbox"/> Tetanus	Other Immunizations:
<input type="checkbox"/> Polio	<input type="checkbox"/> COVID-19 – 1 st Dose
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	<input type="checkbox"/> COVID-19 – 2 nd Dose
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> COVID-19 – 3 rd Dose
<input type="checkbox"/> 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 _____