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
	❑ **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 _____