

Child Care Registration Form (for family home or center program)		Date child entered care	Date child left care
Child's name (Last, First, Middle)		Name used (Nickname)	Birthdate
Street address		City	Zip code
Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone # () -	home phone # () -	alternate phone # () -
Street address		City	Zip code
Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone # () -	home phone # () -	alternate phone # () -
<i>I give my permission for any of the following individuals to be contacted and my child may be released to any of them.</i> Parent/Guardian signature: _____ Date: _____			
In an emergency, if you are not able to contact me, contact the following:			
Name (first and last)	cell phone #	home phone #	alternative phone #
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
These individuals also have permission to pick up my child:			
Name (first and last)	cell phone #	home phone #	alternative phone #
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
Child's health information			
Child's medical care provider or parent's/guardian's preferred medical facility for treatment Name: _____ Phone: () - Street Address: _____		Child's last physical exam, if available	
Child's dental care provider or parent's/guardian's preferred dental facility for treatment Name: _____ Phone: () - Street Address: _____		Child's last dental exam, if available	
Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.)			

Consent to medical care and treatment of minor children

I give permission that my child, _____ may be given
first aid/emergency treatment by the child care licensee and or qualified staff at:

Name of Licensee: Carolyn Reynolds

Address of Licensee: 17215 191st Ave NE Woodinville, WA 98072

Parent/guardian signature

Date

Parent/guardian signature

Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature

Date

Parent/guardian signature

Date