



# Registration Form

Child's Full Name: \_\_\_\_\_

Starting Date (YY/MM/DD): \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_

Date of Birth (YY/MM/DD): \_\_\_/\_\_\_/\_\_\_

Name the child responds to: \_\_\_\_\_

Address (if more than one residence, please give all addresses: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Person(s) with whom the child lives (adults and children): \_\_\_\_\_

Child's first language: \_\_\_\_\_ Other languages: \_\_\_\_\_

Parent(s)/Guardian(s):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Days/Hours of work: \_\_\_\_\_ email: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Days/Hours of work: \_\_\_\_\_ email: \_\_\_\_\_

**Please list all persons authorized to pick up the child and be contacted in case of emergency. Include parents/guardians.**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_



# Registration Form

**If appropriate, list an English speaking contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Has the child previously attended daycare/preschool?**

Yes

No

Comments: \_\_\_\_\_

**Comments/instructions to help us care for your child. Please feel free to add additional pages.**

Toileting/diapering (special words): \_\_\_\_\_

Rest time: \_\_\_\_\_

Eating/Mealtime (include food likes/dislikes: \_\_\_\_\_

\_\_\_\_\_

Fears: \_\_\_\_\_

Please tell us anything else you think will help us provide an enriching experience for your child:

\_\_\_\_\_

\_\_\_\_\_

## **Health Information:**

Health professionals involved with your child (other than doctor and dentist):

Name

Profession/Agency

Phone

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Does your child have:**

A medical condition/concern? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, provide further information: \_\_\_\_\_



# Registration Form

Allergies? Y \_\_\_\_ N \_\_\_\_

If yes, provide further information: \_\_\_\_\_

Asthma? Y \_\_\_\_ N \_\_\_\_

If yes, provide further information: \_\_\_\_\_

Has your child had a seizure in the past year? Y \_\_\_\_ N \_\_\_\_

If yes, provide further information: \_\_\_\_\_

Does your child require a special diet related to a medical condition? Y \_\_\_\_ N \_\_\_\_

If yes, provide further information: \_\_\_\_\_

Food sensitivities? Y \_\_\_\_ N \_\_\_\_

If yes, provide further information: \_\_\_\_\_

List all prescription and 'over the counter' medications your child receives:

Medication	Times Given	Reason for Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

You may be asked to complete additional forms if you answered yes to any of the above.

Information provided by:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Information received by:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office use only: Date child leaves facility: \_\_\_\_\_ Staff initials: \_\_\_\_\_