Admission Date_____
2 days_____ 1day _____

Parent's Day Out Registration Information

Child's Name _____ Nickname _____

Address: _____
Street City Zip

Home Phone _____ Birth date ____/____/____ Sex ____ Race/Ethnicity _____

Father or Guardian's Name _____

Father or Guardian's Employment _____

Work Number _____ Cell Phone _____ Pager _____

Mother or Guardian's Name_____

Mother or Guardian's Employment _____

Work Number _____ Cell Phone _____ Pager _____

Child lives with: (Check one) Both parents _____ Mother _____ Father _____ Legal Guardian_____

If legal guardian, list name, address, phone number if other than above:

_____

Family religious preference _____ Church membership _____

In the event I cannot be reached, please call (these individuals are also authorized to pick-up my child):

Name	Relation to the Child	Address	Phone
1.			
2.			
3.			
4.			

Medical Information for (Child's Name) _____

Family Doctor _____ Address _____ Telephone_____

List any serious allergies (such as insect bites, food allergies, drugs, etc.) or special medications

_____

_____

What is your child's health history and current health problems, if any (include any speech, hearing, or vision problems)

_____

_____

Are your child's immunizations up to date? _____ What is your child's blood type? _____

When was your child's last: Tetanus shot ___/___/___ TB test ___/___/___ Sickle Cell test ___/___/___

Has your child had any of the following? (Please check)

Chicken pox ( ) Yes ( ) No	Measles ( ) Yes ( ) No	Whooping Cough ( ) Yes ( ) No
German Measles ( ) Yes ( ) No	Mumps ( ) Yes ( ) No	Rubella ( ) Yes ( ) No
Scarlet Fever ( ) Yes ( ) No	Rheumatic Fever ( ) Yes ( ) No	Other:

Authorization for Emergency Medical Attention for (Child's Name)_____

In the event that I cannot be reached for emergency medical attention, I authorize the facility director or person in chare to take my child to:

Name of Physician: _____ Address: _____ Telephone # _____

Name of Hospital or clinic: _____ Address: _____ Telephone # _____

I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.

_____ _____
Parent or Guardian's Signature Date

How did you hear about our program? _____

By signing this form, you verify that all of the information provided is correct to the best of your knowledge.

_____ _____
Parent or Guardian's Signature Date

_____ _____
Caregiver's Signature Date

Changes: In the event that any information on this form changes, please notify us immediately. Thank you.