CHILD ENROLLMENT & EMERGENCY MEDICAL CARE FORM

Date of Application: _____ Date of Enrollment: _____ Last Day of Enrollment: _____

Child's Name: _____ Child's Date of Birth: _____

Child's Address: _____ City: _____ Zip Code _____

Mother's Name: _____Address: _____

City: _____ Zip Code: _____e-mail Address: _____

Home Telephone #: (_____) _____ Cell #: (_____) _____

Mother's Employer: _____ Work #: (_____) _____

Mother's Employer Address: _____ City: _____ Zip Code _____

Father's Name: _____Address: _____

City: _____ Zip Code: _____e-mail Address: _____

Home Telephone #: (_____) _____ Cell #: (_____) _____

Father's Employer: _____ Work #: (_____) _____

Father's Employer Address: _____ City: _____ Zip Code _____

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Weekly Care Schedule: (please include the child's hours in care for each day)

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Persons permitted to remove the child from the day care home on behalf of parent. (Use back for additional names.)

Name: _____

Phone #: _____Relationship _____

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In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.

(Use back for additional names.)

Name: _____

Phone #: _____Relationship _____

Known Allergies: _____ Last Tetanus: _____

Insurance Carrier: _____ Insurance ID: _____

Medical Facility: _____ Phone #: (_____) _____

Child's Physician:

Name: _____ Phone #: (_____) _____

Address _____City:_____ Zip Code: _____

Child's Dentist:

Name: _____ Phone #: (_____) _____

Address _____City:_____ Zip Code: _____

I give my consent for the day care provided named _____, to contact the above named physician or dentist if my child has a medical emergency. I understand that if my child's physician or dentist is not available, another physician or dentist may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____. I will be responsible for all medical charges. (hospital or walk-in clinic)

(Provider's name) _____, my child care provider, has my permission to transport my child if necessary, when my child is in care.

Is your child related to the person providing his/her child care? ☐No ☐Yes, if yes, what is the relationship? (Relationship – grandchild, niece, nephew, sibling, son or daughter by blood, adoption or marriage)_____ The provisions outlined on this form have been worked out in consultation with me and have my approval.

Signature of Parent or Guardian: _____ Date: _____

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Attention Provider: This information must be kept current at all times. Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable. This form must be kept on file for one year after the child is no longer enrolled in the child care home.