

Registration Form

Child's Name: _____ D.O.B.: _____

Parents are (Married / Separated / Divorced / Widowed / Single / Deceased)

(Please circle one)

Child Lives with: (Both Parents / Father / Mother / Other) _____

(Please circle one)

Person responsible for paying for childcare: _____

Mother or Guardian #1 Information

Name: _____ Home Phone: _____

Address: _____
(Street) (City) (State) (Zip)

Cell Phone: _____ Email address _____

Best phone number to be reached _____

Employer Information

Company Name _____ Work Phone: _____

Address _____

Father's or Guardian #2 Information

Name: _____ Phone: _____

Address: _____
(Street) (City) (State) (Zip)

Cell Phone: _____ Email address _____

Best phone number to be reach _____

Employer Information

Company _____ Work Phone: _____

Address _____

Emergency Contact #1

Relationship: _____

Name: _____

Phone: _____

Address: _____
(Street) (City) (State) (Zip)

Cell / Other Phone: _____

Emergency Contact #2

Relationship: _____

Name: _____

Phone: _____

Address: _____
(Street) (City) (State) (Zip)

Cell / Other Phone: _____

Medical Info

Doctor's Name: _____ Phone: _____

Address _____

Preferred Hospital: _____ Phone: _____

Address: _____

Dentist's Name _____ Phone Number _____

Address _____

Parent / Guardian Signature Printed Name Relationship Date

Parent / Guardian Signature Printed Name Relationship Date

Non - Prescription Medication Permission

Child's Name: _____

I authorize Elisana Lostaunau to administer the following products on an as needed or as directed basis, in accordance with the manufacturer's directions.

Baby Wipes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diaper Ointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Baby Lotion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sunscreen	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anti-Bacterial Ointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Insect Repellent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vaseline	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Baby Wipes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Band-aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anti-Itch Cream	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Decongestant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Antihistamine	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List any other **non - prescription** medications that you authorize application of:

Parent / Guardian Signature

Printed Name

Relationship

Date

Child's Health Record

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

Does your child have any of the following?

Known Allergies / Sensitivities Check One If "Yes", please describe below:

Medications: Yes No

Food: Yes No

Other: Yes No _____

Has your child ever had any of the illnesses listed below?

Chicken Pox Yes No Date: _____ Measles Yes No Date: _____

Whooping Cough Yes No Date: _____ German Measles Yes No Date: _____

Mumps Yes No Date: _____ Rubella Yes No Date: _____

Rheumatic Fever Yes No Date: _____ Scarlet Fever Yes No Date: _____

(If you answered "Yes" to any of the above illnesses, please list the month / year that it occurred)

Does your child frequently suffer from any of the following?

Headaches Yes No

Ear Infections Yes No

Sore Throats Yes No

Upset Stomach Yes No

Other (please describe):

Does your child have any of the following?

Visual Impairment Yes No

Physical Impairment Yes No

Hearing Impairment Yes No

Emotional Problems Yes No

Please provide details here:

Has your child had any surgeries? Yes No

If you answered "Yes" above, please give details with dates below:

Are all of your child's required immunizations current? Yes No

If you answered "No" above, please list which immunizations are needed

My child's Medical Provider is: _____

Doctor _____

Address: _____

Phone: _____

Parent / Guardian Signature	Printed Name	Relationship	Date
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Permission to Photograph

Today's Date: _____

Child's Name: _____

I _____ grant

permission to photograph / videotape my child for the following reasons:

(Please check one)

Use photographs on bulletin board, scrapbook or other similar uses

Yes No

Use photographs for promotional materials

Yes No

Give video to current parents of enrolled children

Yes No

Use video for promotional on the web. (you tube, facebook)

Yes No

Use video for the Early Childhood Development Day Care web site.

Yes No

I understand that my child will not be identified by name on the web site and the photos will be used for purposes pertaining to the day care and for no other reason.

Parent / Guardian Signature

Printed Name

Relationship

Date

Permission to Photograph

Today's Date: _____

Child's Name: _____

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Parent / Guardian Signature

Printed Name

Relationship

Date

Emergency Transportation and Treatment Authorization

Today's Date: _____

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I (grant / decline) permission for: *Elisana Lostaunau* to take my child:

(Child's name)

to the nearest hospital, medical, or dental facility for treatment for any accident or illness as deemed necessary by the provider.

I accept full liability for all treatment and ambulance expenses.

Signature Printed Name Relationship

Decline option: I wish the following action to be taken in the event of a medical or dental emergency:

Parent / Guardian Signature Printed Name Relationship Date

Media use permission

Child's Name: _____ Age: _____

I do / do not give permission for my child to use or view the following:

	YES	NO
Educational Video Viewing (15 to 20 min per session two or three times per day)	_____	_____
Music (kids musics)	_____	_____
Computer Use (educational programs 20 min)	_____	_____
Other: _____	_____	_____

Regulations for facilities caring for children require that media use is permitted only with the written approval of a child's parent or guardian, including appropriate time limits.

These activities must not contain violence, profanity, nudity, sexual, or inappropriate content.

All children must be provided with an alternative activity once the child/children lose interest in the media activity.

Parent / Guardian Signature

Printed Name

Relationship

