Enrollment Record

Date of Enrollment: _____

Child's Name: _____ Nickname: _____

Home Address: _____

Home Phone: _____ Sex M/F Age: _____ DOB: _____

Family Members: _____

Mother's/Guardian's Name: _____

Address (if different from child's): _____

Home Phone: _____ Cell: _____

Email: _____

Place of Employment (Mother/Guardian): _____

Address of Employment (Mother/Guardian): _____

_____

Work Phone: _____

Special Instructions for reaching Parent/Guardian: _____

Father's/Guardian's Name: _____

Address (if different from child's): _____

Home Phone: _____ Cell: _____

Email: _____

Place of Employment (Father/Guardian): _____

Address of Employment (Father/Guardian): _____

_____

Work Phone: _____

Special Instructions for reaching Parent/Guardian: _____

Emergency Contacts

Child's Name: _____ DOB: _____

1. Name: _____ Cell Phone: _____

Address: _____

Home Phone: _____ Work Phone: _____

Relationship to Child: _____

2. Name: _____ Cell Phone: _____

Address: _____

Home Phone: _____ Work Phone: _____

Relationship to Child: _____

Child Pick Up Information

Persons authorized to pick up your child (Must show photo ID)

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Medical Information

Child's Name: _____ DOB: _____

Name, address and phone number of Child's doctor: _____

_____

Name, address and phone number of Child's dentist: _____

_____

Hospital of Preference: _____ Phone #: _____

Hospital address: _____

Chronic Medical conditions: _____

Does your child have a health care plan? _____ If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? _____ Completed immunization records must be provided on or before the first day the child is in care.

Food Allergies? _____

HEALTH HISTORY (Y/N)

(Chronic or recurring)

Ear Infections _____

Diabetes _____

Heart disease/defect _____

Convulsion/seizures _____

Asthma _____

Nosebleeds _____

Measles _____

Mumps _____

Chicken Pox _____

Flu or Flu Shot _____

ALLERGIES (Y/N

(Nature of Reaction)

Hay Fever _____

Plant Poisoning _____

Insect Stings _____

Penicillin _____

Other drugs _____

Animals _____

Food _____

Other _____

Operations or serious injuries (dates) _____

Is the child on any medications? _If yes, please describe _____

_____

Physical limitations? _____ If yes, please describe _____

Dietary limitations? _____If yes, please describe _____

Vision? _____ Hearing? _____Are there any activities that you prefer your child not to participate in? _____

(Stepping Stones Preschool Medical Information Continued)

If so, please list: _____

Authorization for Emergency Medical Care

I hereby give my permission to Stepping Stones Preschool to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____.

I understand that the child care provider will make a conscientious effort to locate the parents/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate parents/guardians or emergency contacts listed, treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment incurred.

Child's Name: _____ DOB: _____

Parent/Guardian Signatures

_____ Date_____

(Mother/Guardian)

_____ Date_____

(Father/Guardian)