

REGISTRATION FORM

First Day of Care _____

Child's name: _____

Child's address: _____

Child's preferred name: _____

Father's name: _____

Sex: _____ Date of Birth: _____

Business address: _____

Home address: _____

Mother's name: _____

Home tel. _____ Business tel. _____

Business address: _____

Home address: _____

Home tel. _____ Business tel. _____

Person(s) authorized to take child from facility.

Name: _____ Address: _____ Tel. # _____

Name: _____ Address: _____ Tel. # _____

I understand and agree to adhere to all policies set forth by this facility. I understand that my child may be transported in medical emergencies. Any other transportation shall be agreed on separately.

I also understand that a child cannot be left longer than 14 hours in any 24 hour period and that my failure to pick up my child within that time will result in the local police and Social Services being notified of the incident which may result in my child being placed in a foster home.

Date

Signed: _____

Parent or Guardian

WC DSS 307 (Rev.02/05)

(Over)

TO PARENTS: From time to time accidents and illnesses occur at the facility which we must care for, some of them are emergencies in nature. Please fill in the proper blanks and sign so that we may care for your child in keeping with your wishes.

1. In case of an illness or accident which is not serious in nature, but the student would be better off at home, the facility may contact you by:

a. Calling our home telephone number _____

b. Calling our business telephone _____

c. Calling our neighbor (name) _____ telephone no. _____

d. Some other way - please state _____

2. I give permission to obtain emergency medical care. If physician or hospital services are needed I request that

Doctor _____ telephone no. _____

Address _____ be called if possible.

Insurance Carrier _____ Hospital: _____

Medical Alert Information: _____

Allergies to medication, etc.

3. I hereby certify that, to the best of my knowledge, my child does not have an ailment or an organic defect which would be dangerous to his/her health and that he/she is able to participate in the routine program. I further certify that to the best of my knowledge, my child does not have a contagious disease.

4. I understand that a current immunization record must be on file prior to leaving my child in care and that a statement of good health from a physician or nurse is required within 30 days of enrollment. I also understand that failure to provide or keep these records current may result in exclusion of my child from the program.

Parent or Guardian