



Child Registration Form

Date Child Entered Care: _____ Date Child Left Care: _____

Child's Name:

Last: _____ First: _____ Middle: _____

Name (Nickname) Used: _____ Birth Date: _____

Street Address: _____ City: _____ Zip Code: _____

Child's Parent/Guardian Name: _____ Home Phone: _____

Cell Phone: _____ Alternative Phone: _____

Street Address: _____ City: _____ Zip Code: _____

Address where you can be reached while child is in care: _____

City: _____ Zip Code: _____

Child's Parent/Guardian Name: _____ Home Phone: _____

Cell Phone: _____

Alternative Phone: _____

Street Address: _____ City: _____ Zip Code: _____

Address where you can be reached while child is in care: _____

City: _____

Zip Code: _____

Other than you, who else has permission to pick up your child?

Name	Address	Telephone Number
Name: _____ Relationship: _____		Home: _____ Cell: _____
Name: _____ Relationship: _____		Home: _____ Cell: _____
Name: _____ Relationship: _____		Home: _____ Cell: _____
Name: _____ Relationship: _____		Home: _____ Cell: _____

In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian Signature: _____

Name	Address	Telephone Number
Name: _____ Relationship: _____		Home: _____ Cell: _____
Name: _____ Relationship: _____		Home: _____ Cell: _____
Name: _____ Relationship: _____		Home: _____ Cell: _____

Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file)

Name	Reason

Child's Health Information

Date of child's last physical exam: _____

Child's health care provider: _____ Telephone Number: _____

Street Address: _____ City: _____ Zip Code: _____

Special health problems? Yes or No? If yes, specify. _____

Allergies, including drug reactions? Yes or No? If yes, specify. _____

Regular medications? Yes or No? If yes, specify. _____

Other important information. Yes or No? If yes, specify. _____

Child's Parent/Guardian Name: _____ Home Phone: _____

Street Address: _____ City: _____ Zip Code: _____

Child's Medical Insurance Coverage

Insurance Company Name: _____ Member/Policy Number: _____

Policy Holder Name: _____ Employer Name: _____

Insurance Company Name: _____ Member/Policy Number: _____

Policy Holder Name: _____ Employer Name: _____

Consent to Medical care and treatment of minor Children

I give permission that my child _____, may be given first aid/emergency treatment by a the child care license and/or qualified staff at:

Name of Licensee: _____

Address of Licensee: _____

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician , health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child’s health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____