

## INDEX

### **ADMISSION PROCEDURES**

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**EMERGENCY INFORMATION & AUTHORIZATION FOR TREATMENT & TRANSPORTATION**

**Child's Name** \_\_\_\_\_ Nickname \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street City/State Zip

**Parent/Guardian Name** \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_  
Last First

Employer / School \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Street City/State Zip

**Parent/Guardian Name** \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_  
Last First

Employer / School \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Street City/State Zip

**Alternate Emergency Contact:**

(1) \_\_\_\_\_  
Name Relationship Phone Number Cell Phone Pager  
Address \_\_\_\_\_

(2) \_\_\_\_\_  
Name Relationship Phone Number Cell Phone Pager  
Address \_\_\_\_\_

**(Front of Card)**

**Additional Person Authorized to Pick up Child:**

(1) \_\_\_\_\_  
Name Relationship Phone Number Cell Phone Pager  
Address \_\_\_\_\_

(2) \_\_\_\_\_  
Name Relationship Phone Number Cell Phone Pager  
Address \_\_\_\_\_

**Health Care Facility** \_\_\_\_\_  
Name Address (if known) Phone Number Pager

**Allergies/Reactions** \_\_\_\_\_

**Chronic Illnesses/Special Needs** \_\_\_\_\_

**Medications** \_\_\_\_\_

**Insurance Information** \_\_\_\_\_

**Authorization for emergency medical care and transportation:**

In the event of an emergency I hereby give my permission for child care staff to access emergency medical services for my child, including transport to the nearest health care facility, to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be made to locate me, and I accept the expense of care and transport.

\_\_\_\_\_  
**Parent/Guardian Signature**                      **Date**                      **Parent/Guardian Signature**                      **Date**

**Child Care Facility** \_\_\_\_\_  
Name Address Phone Cell Phone

**SAMPLE CHILDREN'S ENROLLMENT RECORD**

**Date of Enrollment** \_\_\_\_\_

**Child's Name** \_\_\_\_\_ **Nickname** \_\_\_\_\_

**Home Address** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Sex** M F **Age** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Family Members:** \_\_\_\_\_

**Mother or Guardian's Name** \_\_\_\_\_

**Address if different from child's** \_\_\_\_\_

**Zip** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_ **Email** \_\_\_\_\_

**Name of employment (mother/guardian)** \_\_\_\_\_

**Address of employment (mother/guardian)** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Father or Guardian's Name** \_\_\_\_\_

**Address if different from child's** \_\_\_\_\_

**Zip** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_ **Email** \_\_\_\_\_

**Name of employment (father/guardian)** \_\_\_\_\_

**Address of employment (father/guardian)** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Special instructions for reaching parent or guardian** \_\_\_\_\_

**EMERGENCY CONTACTS**

**1. Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Address** \_\_\_\_\_

**Work Phone** \_\_\_\_\_ **Relationship to child** \_\_\_\_\_

**2. Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Address** \_\_\_\_\_

**Work Phone** \_\_\_\_\_ **Relationship to child** \_\_\_\_\_

**CHILD PICK UP INFORMATION**

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

**Name** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Name** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Name** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Name, address and phone number of child's doctor** \_\_\_\_\_

\_\_\_\_\_

**Name, address and phone of child's dentist** \_\_\_\_\_

\_\_\_\_\_

- Hospital of Preference (Please check one)**
- The Children's Hospital**  
13123 East 16<sup>th</sup> Avenue  
Aurora, CO 80045  
720-777-1234
  - Insert Nearest Local Hospital**
  - Insert Nearest Local Kaiser Permanente Hospital**
  - Other** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Chronic Medial 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**

**(Chronic or recurring)**

Ear Infections \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Heart disease/defect \_\_\_\_\_  
Convulsion/seizures \_\_\_\_\_  
Asthma \_\_\_\_\_  
Nosebleeds \_\_\_\_\_  
Measles \_\_\_\_\_  
Mumps \_\_\_\_\_  
Chicken Pox \_\_\_\_\_  
Flu or Flu shot \_\_\_\_\_

**ALLERGIES**

**(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? (Explain) \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Physical limitations \_\_\_\_\_ Describe if yes \_\_\_\_\_

Dietary limitations \_\_\_\_\_ Describe if yes \_\_\_\_\_

Vision \_\_\_\_\_ Hearing \_\_\_\_\_

**Are there any activities that you prefer that your child NOT participate in?**

If so please list: \_\_\_\_\_

**Authorization for Emergency Medical Care**

I hereby give my permission to \_\_\_\_\_ 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, \_\_\_\_\_.

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

Parent/Guardian signatures

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_