DO NOT LEAVE ANY FIELDS BLANK. IF INFORMATION IS UNKNOWN OR NOT APPLICABLE, PUT UNK, N/A.

CHILD REGISTRATION FORM

CHILD'S NAME: _____NICK NAME: _____ DATE OF BIRTH:_____ SEX:_____

ADDRESS: _____CITY: _____STATE: ____ZIP: _____

CHRONIC PHYSICAL PROBLEMS/DEVELOPMENTAL INFORMATION/SPECIAL NEEDS ACCOMODATIONS:

_____

ALLERGIES/INTOLERANCE TO FOOD, MEDICATION, AND ACTIONS TO TAKE IN AN EMERGENCY: _____

_____

CHILD'S PHYSICIAN: _____ PHONE#_____

PHYSICIAN ADDRESS: _____CITY: _____STATE: ____ZIP: _____

PREVIOUS CHILD CARE/SCHOOLS: _____

PARENT /GUARDIAN: _____

SS#: _____

ADDRESS: _____

CITY: _____STATE: ____ZIP:_____

HOME #: _____WORK #:_____

CELL#_____CARRIER_____

EMPLOYER: _____

ADDRESS: _____

CITY: _____STATE: ____ZIP:_____

EMAIL ADDRESS: _____

PARENT /GUARDIAN: _____

SS#: _____

ADDRESS: _____

CITY: _____STATE: ____ZIP:_____

HOME #: _____WORK #:_____

CELL#_____CARRIER_____

EMPLOYER: _____

ADDRESS: _____

CITY: _____STATE: ____ZIP:_____

EMAIL ADDRESS: _____

NAME OF PERSON(S)/AGENCY WITH LEGAL CUSTODY: _____

PLEASE LIST 2 CONTACTS, OTHER THAN THE PARENTS THAT CAN BE NOTIFIED IN CASE OF EMERGENCY

1. NAME: _____PHONE: _____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

2. NAME: _____PHONE: _____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

PLEASE LIST PERSONS OTHER THAN THE PARENTS THAT ARE AUTHORIZED TO PICK YOUR CHILD UP.

NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____

PERSONS NOT AUTHORIZED TO PICK UP YOUR CHILD _____

WE CANNOT DENY ACCESS FROM A BIOLOGICAL PARENT. CUSTODY PAPERS MUST BE ON FILE. (SEE BACK)

DO NOT LEAVE ANY FIELDS BLANK. IF INFORMATION IS UNKNOWN OR NOT APPLICABLE, PUT UNK, N/A.

RELEASE OF MEDICAL INFORMATION

I authorize Steppin Stones staff to obtain from my physician information concerning my child.

Parent/Guardian Signature_____ Date_____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

I authorize Steppin Stones staff to obtain all necessary care for my child. I authorize Steppin Stones staff to obtain immediate medical care and understand that I am responsible for full payment of all medical bills.

Signature of Parent/Guardian_____Date _____

Insurance Provider_____ Policy Holder_____ Policy #_____

ILLNESS

Steppin Stones staff agrees to notify the parent/guardian whenever the child becomes ill. In the event of emergency or illness I will make arrangements for my child to be picked up from the center within one hour after I am notified. I also agree to notify Steppin Stones within 24 hours or the next business day in the event my child or any of my family members have been exposed to a communicable disease. Life threatening diseases must be reported immediately.

Parent/Guardian Signature_____ Date_____

FIELD TRIPS/TRANSPORTATION/COMMUNITY WALKS

I authorize my child to be transported in center-sponsored field trips for Steppin Stones and be transported for such activities.

I authorize my child to be transported to/from school or home if needed.

Parent/Guardian Signature_____ Date_____

I authorize my child to participate in community walks.

Parent/Guardian Signature_____ Date_____

PHOTOS

I authorize Steppin Stones to take photographs of my child for class projects, school displays, publicity, websites, etc.

Parent/Guardian Signature_____ Date_____

I authorize Steppin Stones to post my child's picture, name, and allergy throughout the center and on the centers' vehicle.

Parent/Guardian Signature_____ Date_____

WATER EXPERIENCES

I authorize for my child to participate in water activities at the center and on field trips.

Parent/Guardian Signature_____ Date_____

OFFICE USE ONLY

BIRTH LETTER_____ BIRTH CERTIFICATE #_____ BIRTH PLACE_____

DATE ISSUED_____ DATE VIEWED_____ PERSON VIEWING DOCUMENT_____

ADMINISTRATOR/DIRECTOR SIGNATURE: _____ Date: _____

ENROLLMENT DATE: _____ WITHDRAWAL DATE: _____ANNUAL UPDATE: _____

PLEASE INITIAL WHEN FILE IS CHECKED. ASST DIR.: _____ DIRECTOR: _____ADM.:_____