REGISTRATION FORM

Please complete all fields on this registration form as all information is required by DHS.

CHILD'S INFORMATION

Last Name: ______________________ First Name: ______________________
Nickname: ______________________ Birth Date: ______________________
Address: ______________________ City, State, Zip: ______________________
Start Date: ______________________ Classroom: ______________________

Name of siblings and birthdates: ______________________
Most recent child care provider: ______________________ ☐ In Home ☐ Center
Who does the child live with? ______________________

FAMILY INFORMATION

MOTHER / GUARDIAN #1:
Last Name: ______________________ First Name: ______________________
Relationship to Child: ______________________ Cell Phone: ______________________
Address: ______________________ Can you receive texts? ☐ Yes ☐ No
City, State, Zip: ______________________ Employer: ______________________
Email: ______________________ Work Phone: ______________________
Which is the best method of communication during the day? ☐ Work ☐ Cell ☐ Email ☐ Text

FATHER / GUARDIAN #2:
Last Name: ______________________ First Name: ______________________
Relationship to Child: ______________________ Cell Phone: ______________________
Address: ______________________ Can you receive texts? ☐ Yes ☐ No
City, State, Zip: ______________________ Employer: ______________________
Email: ______________________ Work Phone: ______________________
Which is the best method of communication during the day? ☐ Work ☐ Cell ☐ Email ☐ Text

ATTENDANCE

My child/ren is / are enrolled in New Creations Child Care and Learning Center and will attend New Creations from approximately _________ a.m. to _________ p.m. on the following days:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

EMERGENCY INFORMATION

EMERGENCY / AUTHORIZED PICK UP CONTACTS
Your child will ONLY be released to an authorized person listed on this form. In case of an emergency or an unforeseen circumstance, please indicate the name, relationship, phone number and full address of any other persons who you authorize to pick up your child on your behalf. ***Names listed below must be someone OTHER THAN Parent / Guardian***. Please list in order of preferred contact. All blanks must be filled in.

1. Name: ______________________ Relationship to Child: ____________
   Phone: ____________ Full Address: ______________________
2. Name: ______________________ Relationship to Child: ____________
   Phone: ____________ Full Address: ______________________
3. Name: ______________________ Relationship to Child: ____________
   Phone: ____________ Full Address: ______________________

A parent / guardian's verbal authorization for pick up must be received before your child will be released to anyone not listed above. If not received, and we cannot get in touch with you by phone, your child will NOT be released

MEDICAL / DENTAL INFORMATION

Preferred Hospital: ______________________ Office Phone: ____________
Address: ______________________ City, State, Zip: ____________

Pediatrician: ______________________ Office Phone: ____________
Address: ______________________ City, State, Zip: ____________
Medical Insurance Co: ______________ Child's Personal ID# ____________
Allergies or Medical conditions / needs: ______________________

Dentist: ______________________ Office Phone: ____________
Address: ______________________ City, State, Zip: ____________
Please use your dentist even if your child is not yet being seen. All blanks must be filled in

EMERGENCY CONSENT

It is our policy to notify a parent when a child is ill or needs medical attention. Occasionally, we cannot contact a parent and we need to get immediate help for the child. Our procedure is to take the child to the nearest emergency service.

Please sign below so that we may take appropriate action on behalf of your child.

I / WE HEREBY GIVE MY / OUR CONSENT FOR MY CHILD ______________________
WHEN ILL / INJURED TO BE TAKEN TO THE NEAREST EMERGENCY CENTER BY THE STAFF OF NEW CREATIONS CHILD CARE AND LEARNING CENTER WHEN I / WE CANNOT BE CONTACTED. I CONSENT TO AN AMBULANCE BEING CALLED TO TRANSPORT THE CHILD, IF NECESSARY. I FURTHER AGREE TO PAY ALL COSTS INCURRED FOR TRANSPORT.

______________________ ____________
Parent / Guardian Signature Date

______________________ ____________
Director Signature Date

HEALTH AND MEDICAL HISTORY

Has your child ever had any of the following? Check all that apply.

☐ Chicken Pox	☐ Scarlett Fever	☐ Diabetes	☐ Measles
☐ HIV	☐ Aids	☐ Hepatitis A	☐ Hepatitis B
☐ Mumps	☐ Asthma	☐ Other - Explain:	______________

Does your child frequently have any of the following? Check all that apply.

☐ Ear Aches	☐ Colds	☐ Sore Throat	☐ Stomach Aches

Does he / she vomit easily? ☐ Yes ☐ No
Run high fevers easily? ☐ Yes ☐ No
Has your child had any serious accidents? ☐ Yes ☐ No
If yes, please explain: ____

____

Does your child have any allergies? ☐ Yes ☐ No If yes, please explain what allergies your child has and when / how it manifests (asthma, hay fever, hives, etc.):

____

____

Has your child ever been hospitalized? ☐ Yes ☐ No
If yes, please explain: ____

____

Has your child ever been to a dentist? ☐ Yes ☐ No
Does your child have any disabilities or exceptionalities we need to be aware of? ☐ Yes ☐ No
If yes, please explain: ____

____

How do you find your child's overall health to be?

____

____

______________________________ ______________ ________

Parent / Guardian Signature Relationship to Child Date

TO BE FILLED OUT BY NEW CREATIONS

Parent / Teacher Conference Date #1 ______________________________
Summary:

____

____

Parent / Teacher Conference Date #2 ______________________________
Summary:

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