Enrollment Date: _____/_____/_____

Registration for Childcare

This information will be kept confidential at all times.

Child's Full Name: _____ D.O.B.: ____/____/_____

Nickname: _____ Child's Address: _____

Lives With (circle one): MOM DAD OTHER: _____

Parent Contact Information:

Mother's Name: _____

Cell: _____ Work: _____ Home: _____

Mother's Email: _____

Father's Name: _____

Cell: _____ Work: _____ Home: _____

Father's Email: _____

Child's Physician:

Name: _____ Phone: _____

Address: _____

Health Information:

Medical Conditions: _____

Allergies: _____

Additional Information: _____

Person(s) other than parents who may be contacted in case of an emergency:

1) Name: _____ Phone: _____ Phone: _____

   Relationship: _____ Address: _____

2) Name: _____ Phone: _____ Phone: _____

   Relationship: _____ Address: _____

Person(s) other than parents who are authorized to pick up your child:

1) Name: _____ Phone: _____ Phone: _____

   Relationship: _____ DL #: _____

2) Name: _____ Phone: _____ Phone: _____

   Relationship: _____ DL #: _____

DO NOT PICK UP- Please list any individuals who are NOT allowed to have contact with or pick up your child(ren):

UPDATED: ____/____/_____

Enrollment Date: _____/_____/_____

Vehicle Emergency Medical Information

This information will be kept confidential at all times

Child's Name: _____DOB: _____

Home Address: _____

Mother's Name _____

Work _____ Cell _____ Home _____

Father's Name _____

Work _____ Cell _____ Home _____

Person(s) to notify in case of an emergency when parents cannot be reached:

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Child's Doctor: _____ Phone _____

Allergies _____

Current Prescribed Medications: _____

Medical Conditions: _____

In the event of illness or accident, which requires immediate medical treatment at a time when a parent cannot be located, I give permission for Little Lights Learning Center staff personnel to authorize such treatment. I will not hold the center or medical personnel responsible. This is done with the understanding that every attempt will have been made to contact the parents, the child's physician, and other persons listed for emergency contact. I agree to be fully responsible for all medical expenses incurred for the treatment of my child.

Child's Name: _____

Parent Signature: _____ Date: _____

Witnessed by: _____ Date: _____

UPDATED: ____/____/_____