PINNACLE CUB'S DEN

CHILDREN'S ENROLLMENT RECORD

Date of Enrollment_____

Child's Name _____Nickname_____

Home Address _____

Home Phone _____Sex M / F   Age _____Date of Birth_____

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_____**Address**_____**Phone**_____

Chronic Medical 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? _____**If yes, the health care plan must be provided on or before the first day the child is in care.**

Food Allergies _____

HEALTH HISTORY   **ALLERGIES**
(Chronic or recurring)   **(Nature of Reaction)**
Ear Infections _____   **Hay Fever**_____
Diabetes_____   **Plant Poisoning**_____
Heart disease/defect_____   **Insect stings**_____
Convulsion/seizures_____   **Penicillin**_____
Asthma _____   **Other drugs**_____
Nosebleeds_____   **Animals**_____
Measles_____   **Food**_____
Mumps_____   **Other**_____
Chicken Pox _____
Flu or Flu shot _____

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 <u>NOT</u> 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 _____