|  |  |  |
| --- | --- | --- |
| **Child Care Registration Form****(for family home or center program)** | Date child entered care      | Date child left care      |
| Child’s name (Last, First, Middle)      | Name used (Nickname)      | Birthdate      |
| Street address City Zip code                  |
| Child’s parent/guardian name      | Circle the best number to contact you at when your child is in our care |
| cell phone #(     )     -      | home phone #(     )     -      | alternate phone #(     )     -      |
| Street address City Zip code                  |
| Child’s parent/guardian name      | Circle the best number to contact you at when your child is in our care |
| cell phone #(     )     -      | home phone #(     )     -      | alternate phone #(     )     -      |
| *I give my permission for any of the following individuals to be contacted and my child may be released to any of them.**Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***In an emergency, if you are not able to contact me, contact the following:** |
| Name (first and last) | cell phone # | home phone # | alternative phone # |
|       | (     )     -      | (     )     -      | (     )     -      |
|       | (     )     -      | (     )     -      | (     )     -      |
|       | (     )     -      | (     )     -      | (     )     -      |
|       | (     )     -      | (     )     -      | (     )     -      |
| These individuals also have permission to pick up my child: |
| Name (first and last) | cell phone # | home phone # | alternative phone # |
|       | (     )     -      | (     )     -      | (     )     -      |
|       | (     )     -      | (     )     -      | (     )     -      |
|       | (     )     -      | (     )     -      | (     )     -      |
|       | (     )     -      | (     )     -      | (     )     -      |
| Child’s health information |
| Child’s medical care provider or parent’s/guardian’s preferred medical facility for treatmentName:       Phone: (     )     -     Street Address:       | Child’s last physical exam, if available      |
| Child’s dental care provider or parent’s/guardian’s preferred dental facility for treatmentName:       Phone: (     )     -     Street Address:       | Child’s last dental exam, if available      |
| Known health conditions (An individual care plan from child’s health care provider is required for any food allergies or special dietary requirement due to a health condition.)  |
| Consent to medical care and treatment of minor children |
| I give permission that my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may be givenfirst aid/emergency treatment by the child care licensee and or qualified staff at:Name of Licensee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address of Licensee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parent/guardian signature | Date | Parent/guardian signature | Date |
| When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures tobe performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemednecessary or advisable by the physician or aid care attendant to safeguard my child’s health. I waive my right of informed consent to such treatment.I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct. |
| Parent/guardian signature | Date | Parent/guardian signature | Date |