



BEST PRACTICE RESOURCE SAMPLE

Registration Form For Child Care

(Please complete both sides of this form for each child)

Date of Enrollment: _____

Name of Child: _____ Birthdate: ____/____/____ Sex: M ___ F ___
yy mm dd

Full name of Parent(s)/Guardian:

- 1. _____
- 2. _____

Address:

- 1. _____
- 2. _____

Telephone Numbers: HOME: 1. _____ WORK: 1. _____
2. _____ 2. _____

Place of work: 1. _____
2. _____

Care Card Number: _____ Family Doctor: _____
Phone Number: _____

PERSONS AUTHORIZED TO CALL FOR THE CHILD AND CONTACT IN EMERGENCY:	
Name	Telephone Number
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Names of other children in family: _____ Birthdate: _____

(yy/mm/dd) _____

(yy/mm/dd) _____

Has the child had previous experience away from home? NO YES If YES, explain:

Do you think your child feels comfortable leaving parents? NO YES If YES, explain:

Special instructions concerning Care, Medication, Diet, or **Custody**:

NO YES **ATTACH DOCUMENTATION**

HEALTH HISTORY

Has this child any known health problems or depressed immune system?

NO YES - If YES, attach documentation.

List communicable diseases child has had: _____

Has he/she had any recent illness? NO YES - If YES: _____

Any allergies? NO YES - If YES, list ALLERGENS: _____

Attach special instructions to follow in the event of an allergic reaction.

What are the child's eating habits? _____

Favorite foods: _____

Strong dislikes: _____

**Basic Schedule and Record of Immunization as submitted by Parent or Guardian
(ATTACH IMMUNIZATION RECORD OR RECORD THE DATES)**

	Date (yy/mm/dd)		Date (yy/mm/dd)
1 st visit – 2 months of age:		4 th visit – 12 months of age:	
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Pertussis	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Tetanus	_____	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Polio	_____	<input type="checkbox"/> Meningococcal C	_____
<input type="checkbox"/> Haemophilus Influenzae Type b (Hib)	_____	5 th visit – 12 months after 3 rd visit:	
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Diphtheria	_____
<input type="checkbox"/> Pneumococcal	_____	<input type="checkbox"/> Pertussis	_____
2 nd visit – 2 months after 1 st visit:		<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Pertussis	_____	<input type="checkbox"/> Haemophilus Influenzae Type b (Hib)	_____
<input type="checkbox"/> Tetanus	_____	<input type="checkbox"/> Measles, Mumps, Rubella	_____
<input type="checkbox"/> Polio	_____	<input type="checkbox"/> Pneumococcal	_____
<input type="checkbox"/> Haemophilus Influenzae Type b (Hib)	_____	4 – 6 years of age:	
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Diphtheria	_____
<input type="checkbox"/> Pneumococcal	_____	<input type="checkbox"/> Pertussis	_____
3 rd visit – 2 months after 2 nd visit:		<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Pertussis	_____	Other Immunizations:	
<input type="checkbox"/> Tetanus	_____	_____	_____
<input type="checkbox"/> Polio	_____	_____	_____
<input type="checkbox"/> Haemophilus Influenzae Type b (Hib)	_____	_____	_____
<input type="checkbox"/> Hepatitis B	_____	_____	_____
<input type="checkbox"/> Pneumococcal	_____	_____	_____

I authorize the child care provider to obtain the following services for this child as necessary: Physician and/or Ambulance in the event of an emergency.

Date

Signature of Parent/Guardian

Signature of Child Care Provider