



# 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 <sup>st</sup> visit – 2 months of age:		4 <sup>th</sup> 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 <sup>th</sup> visit – 12 months after 3 <sup>rd</sup> visit:	
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Diphtheria	_____
<input type="checkbox"/> Pneumococcal	_____	<input type="checkbox"/> Pertussis	_____
2 <sup>nd</sup> visit – 2 months after 1 <sup>st</sup> 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 <sup>rd</sup> visit – 2 months after 2 <sup>nd</sup> 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