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 ☐ 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)
1st visit – 2 months of age:	
☐ Diphtheria	_____
☐ Pertussis	_____
☐ Tetanus	_____
☐ Polio	_____
☐ Haemophilus Influenzae Type b (Hib)	_____
☐ Hepatitis B	
☐Pneumococcal	_____
2nd visit – 2 months after 1st visit:	
☐ Diphtheria	_____
☐ Pertussis	_____
☐ Tetanus	_____
☐ Polio	_____
☐ Haemophilus Influenzae Type b (Hib)	_____
☐ Hepatitis B	_____
☐Pneumococcal	
3rd visit – 2 months after 2nd visit:	
☐ Diphtheria	_____
☐ Pertussis	_____
☐ Tetanus	_____
☐ Polio	_____
☐ Haemophilus Influenzae Type b (Hib)	_____
☐ Hepatitis B	_____
☐Pneumococcal	

	Date (yy/mm/dd)
4th visit – 12 months of age:	
☐ Measles	_____
☐ Mumps	_____
☐ Rubella	_____
☐Meningococcal C	
5th visit – 12 months after 3rd visit:	
☐ Diphtheria	_____
☐ Pertussis	_____
☐ Tetanus	_____
☐ Polio	_____
☐ Haemophilus Influenzae Type b (Hib)	_____
☐ Measles, Mumps, Rubella	_____
☐Pneumococcal	
4 – 6 years of age:	
☐ Diphtheria	_____
☐ Pertussis	_____
☐ Tetanus	_____
☐ Polio	_____
Other Immunizations:	
_____	_____
_____	_____
_____	_____

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