|  **Registration Form** | Date child entered care | Date child left care |
| --- | --- | --- |
| Child’s name Last First Middle | Name (Nickname) used | Birthdate |
| Street address City Zip code |
| Child’s parent/guardian name | home phone #()- | cell phone#  ()- | alternative phone #()- |
| Street address City Zip code |
| Address where you can be reached while child is in care City Zip code |
| Child’s parent/guardian name | home phone #()- | cell phone#  ()- | alternative phone #()- |
| Street address City Zip code |
| Address where you can be reached while child is in care City Zip code |
| Other than you, who else has permission to pick up your child? |
| Name | Address | Telephone number |
| Name: Relationship:  |  | Home: ()- Cell: ()-Alternative: ()-  |
| Name: Relationship:  |  | Home: ()- Cell: ()-Alternative: ()-  |
| Name: Relationship:  |  | Home: ()- Cell: ()-Alternative: ()-  |
| Name: Relationship:  |  | Home: ()- Cell: ()-Alternative: ()-  |
| In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.  Parent/Guardian signature:  |
| Name | Address | Telephone number |
| Name: Relationship:  |  | Home: ()- Cell: ()-Alternative: ()-  |
| Name: Relationship:  |  | Home: ()- Cell: ()-Alternative: ()-  |
| Name: Relationship:  |  | Home: ()- Cell: ()-Alternative: ()-  |
| Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file) |
| Name | Reason |
|  |  |
|  |  |

| Child’s health information |
| --- |
| Date of child’s last physical exam:  | Child’s health care provider | Telephone number()- |
| Street address City Zip code |
| Special health problems?Yes or no? If yes, specify. | Allergies, including drug reactionsYes or no? If yes, specify.  |
| Regular medications? Yes or no? If yes, specify. | Other important informationYes or no? If yes, specify. |
| Child’s dentist’s name | Telephone number()- |
| Street address City Zip code |
| Child’s medical insurance coverage |
| Insurance company name | Member/policy number |
| Policy holder name | Employer name |
| Insurance company name | Member/policy number |
| Policy holder name | Employer name |
| Consent to medical care and treatment of minor children |
| I give permission that my child,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, may be given first aid/emergency treatment by a 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 to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car 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 |