

# CHILD ENROLLMENT & EMERGENCY MEDICAL CARE FORM

**Date of Application:** \_\_\_\_\_ **Date of Enrollment:** \_\_\_\_\_ **Last Day of Enrollment:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ e-mail Address: \_\_\_\_\_

Home Telephone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Mother's Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ e-mail Address: \_\_\_\_\_

Home Telephone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Father's Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code \_\_\_\_\_

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## Weekly Care Schedule: (please include the child's hours in care for each day)

Sunday: \_\_\_\_\_

Monday: \_\_\_\_\_

Tuesday: \_\_\_\_\_

Wednesday: \_\_\_\_\_

Thursday: \_\_\_\_\_

Friday: \_\_\_\_\_

Saturday: \_\_\_\_\_

## Persons permitted to remove the child from the child care home on behalf of parent. (Use back for additional names.)

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship \_\_\_\_\_

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## In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.

(Use back for additional names.)

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship \_\_\_\_\_

Known Allergies: \_\_\_\_\_ Last Tetanus: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Insurance ID: \_\_\_\_\_

Medical Facility: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**Child's Physician:** Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Child's Dentist:** Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I give my consent for **(provider's name)** \_\_\_\_\_, and **(if applicable, approved substitute's name)** \_\_\_\_\_ to contact the above named physician or dentist if my child has a medical emergency. I understand that if my child's physician or dentist is not available, another physician or dentist may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at \_\_\_\_\_ . I will be responsible for all medical charges.

(hospital or walk-in clinic)

**(Provider's name)** \_\_\_\_\_ and **(if applicable, approved substitute's name)** \_\_\_\_\_

have my permission to transport my child away from the home as part of the child care program.

Is your child related to the person providing his/her child care? ☐ No ☐ Yes, if yes, what is the relationship? \_\_\_\_\_

The provisions outlined on this form have been worked out in consultation with me and have my approval.

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Attention Provider:** This information must be kept current at all times. Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable. This form must be kept on file for one year after the child is no longer enrolled in the child care home.