



**Child Care Registration: Fee \$100.00**

PHOTO OF CHILD (Optional)	Child's Full Name: _____ What would be your ideal start date? _____			
	<b>Program:</b> Infant (3 to 12 months)      Toddler (12 to 24 months)      Preschool (2 years old and up)			
	<b><u>FULL-DAY PROGRAM:</u></b> Five days: 8:00 am - 6:00 pm Three days: 8:00 am - 6:00 pm Days: _____ Two days: 8:00 am - 6:00 pm Days: _____			
	<b><u>HALF-DAY PROGRAM:</u></b> Five days:      8:00 am - 1:00 pm or      1:00 pm - 6:00 pm Days: _____ Three days:      8:00 am - 1:00 pm or      1:00 pm - 6:00 pm Days: _____ Two days:      8:00 am - 1:00 pm or      1:00 pm - 6:00 pm Days: _____			
<b><u>INDIVIDUALIZED PROGRAM (SPECIFIC DAYS REQUEST):</u></b> DAYS: _____    TIMES: _____				
Does your child have any allergies?      Yes      No If yes, what is your child allergic to? _____				
Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.				
Child's source of Medical Care/Primary Care Physician's Name: _____			Telephone #: _____	
Name of Medical Care Facility/Hospital: _____			Telephone #: _____	
<b>Emergency Data</b>	<b>RELATIONSHIP</b>	<b>CONTACT NAME</b>	<b>TELEPHONE NUMBER DURING CHILD CARE</b>	<b>Email and other phone</b>
Child's Full Name: _____			Sex:      Male      Female	
Child's Home Address: _____		Date of Birth: _____		
_____		Home Telephone Number: _____		
Name of Parents/Guardian applying for child: _____		Relationship to Child: _____		Home Telephone #: _____
Email (Mother/Guardian): _____		_____		Daytime Telephone #: _____
Email (Father/Guardian): _____		_____		
<b>AGREEMENTS (Please check boxes)</b>				
I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility.      Yes      No				
I give consent for my child to take part in neighborhood trips (i.e. library, park, visit to the local firehouse, post office, and playground) away from the facility under proper supervision.      Yes      No				
In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon, or hospital (listed above) necessary for the proper health and well.      Yes      No				
I agree to review and update this information whenever a chance occurs and at least once every six months.      Yes      No				
SIGNATURE-PARENT OR PERSON(S) LEGALLY RESPONSIBLE				DATE: _____