Fall Enrollment

Date of Enrollment: _____

Contact Information

Child's Name: _____ Nickname: _____
Date of Birth: _____
Allergies:_____
Home Address: _____ City: _____
State: _____ Zip:_____

Mother or Guardian Name: _____
Best Contact Number: _____
Address (if different): _____ City: _____
State: _____ Zip: _____ Email Address:_____
Name of employment: _____ Work Phone: _____
Address of employment: _____

Father or Guardian Name: _____
Best Contact Number: _____
Address (if different): _____City: _____
State: _____ Zip: _____ Email Address:_____
Name of employment: _____ Work Phone: _____
Address of employment: _____

Emergency Contacts

#1 Name: _____
Best Contact Number: _____ Relationship to Child: _____
Address: _____
#2 Name: _____
Best Contact Number: _____ Relationship to Child: _____
Address: _____

Persons authorized to pick up your child (Must Show Photo ID)
#1 Name: _____
Best Contact Number: _____ Relationship to Child: _____
Address: _____
#2 Name: _____
Best Contact Number: _____ Relationship to Child: _____
Address: _____

Medical Information

Primary Care Doctor Name/Practice: _____
Phone Number: _____ Address: _____
Dentist Name/Practice: _____
Phone Number: _____ Address: _____

Preferred Hospital (check one)
Other (Name, Address, Phone): _____

- ❏ Memorial Hospital Main – 1400 Boulder St, 719-365-5000
- ❏ Memorial Hospital North – 8890 Briargate Blvd, 719-365-5000
- ❏ Penrose North Hospital – 2222 Nevada Ave, 719-776-5000
- ❏ St. Francis Medical Center – 6001 E. Woodmen Rd, 719-570-1000

Does your child have a health care plan? Y / N (circle one)
If yes, the health care plan must be provided on or before the first day of care.
Is your child fully immunized? Y / N (circle one)
Completed immunization records must be provided on or before the first day of care.
Please bring us all updated records after receiving new immunizations.

Chronic or Recurring Health History

Allergies & Nature of Reaction Ear Infections: _____
Insect Stings: _____ Diabetes: _____
Medication/Drugs: _____ Heart Disease/Defect: _____
Food: _____ Convulsions/Seizures: _____
Other: _____ Asthma: _____
Nosebleeds: _____
Please list any other chronic conditions: _____
Nature & dates of any surgeries or severe injuries: _____
Is your child on any medications? Y / N (circle one) if yes, please explain: _____
_____
Does your child have any physical limitations? Y / N if yes, please explain: _____
_____
Does your child have any dietary restrictions? Y / N if yes, please explain: _____
_____
Please list any activities that you prefer your child NOT participate in: _____
_____

Authorization for Emergency Medical Care I hereby give my permission to Little Sprouts Learning Center to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____.

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/We will accept the expense of emergency transportation, medical or surgical treatment. Parent/Guardian Signatures:

_____ Date: _____

Print Name: _____

_____ Date: _____

Print Name: _____

Director Signature: _____ Date: _____