Enrollment Record

Please fill out in full detail.

Date of Enrollment: _____

Contact Information

Child's Name: _____ Nickname: _____ Date of Birth: _____

Allergies:_____

Home Address: _____ City: _____ State: _____ Zip: _____

Best Contact Number: _____ Best Email Address: _____

Mother or Guardian

Name: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Name of employment (mother/guardian):_____ Work Phone:_____

Address of employment (mother/guardian): _____

Father or Guardian

Name: _____

Address if different:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Name of employment (father/guardian):_____ Work Phone:_____

Address of employment (father/guardian): _____

Emergency Contacts

Emergency Contact #1 Name: _____ Relationship to Child: _____

Best Contact Number: _____ Address: _____

Emergency Contact #2 Name: _____ Relationship to Child: _____

Best Contact Number: _____ Address: _____

Persons authorized to pick up your child (Must Show Photo ID)

Pickup Authorized #1 Name: _____ Relationship to Child: _____

Best Contact Number: _____ Address: _____

Pickup Authorized #2 Name: _____ Relationship to Child: _____

Best Contact Number: _____ Address: _____

Enrollment Record

Please fill out in full detail.

Medical Information

Primary Care Doctor Name/Practice: _____

Phone Number: _____ Address: _____

Dentist Name/Practice: _____

Phone Number: _____ Address: _____

Preferred Hospital (check one)

- ○ 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 Canter – 6001 E. Woodmen Rd, (719) 570-1000
- ○ Children's Hospital, Briargate - 4090 Briargate Pkwy, (719) 305-1234
- ○ Other (Name, Address, Phone): _____

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

Ear Infections: _____

Diabetes: _____

Heart Disease/Defect: _____

Convulsions/Seizures: _____

Asthma: _____

Nosebleeds: _____

Allergies & Nature of Reaction

Insect Stings: _____

Medication/Drugs: _____

Food: _____

Other: _____

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: _____

_____

Enrollment Record

Please fill out in full detail.

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 childcare 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:** _____

Enrollment Record

Please fill out in full detail.

Date of Enrollment: _____

Contact Information (Classroom Copy)

Child's Name: _____ Nickname: _____ Date of Birth: _____

Allergies:_____

Mother or Guardian

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Father or Guardian

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contacts

Emergency Contact #1 Name: _____ Relationship to Child: _____

Best Contact Number: _____ Address: _____

Emergency Contact #2 Name: _____ Relationship to Child: _____

Best Contact Number: _____ Address: _____

Persons authorized to pick up your child (Must Show Photo ID)

Pickup Authorized #1 Name: _____

Relationship to Child: _____Best Contact Number: _____

Pickup Authorized #2 Name: _____

Relationship to Child: _____Best Contact Number: _____