

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: _____

Parent or Guardian #1

Name: _____

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

Home Phone: _____ Cell Phone: _____ Email: _____

Name of employment (guardian #1): _____ Work Phone: _____

Address of employment (guardian #1): _____

Parent or Guardian #2

Name: _____

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

Home Phone: _____ Cell Phone: _____ Email: _____

Name of employment (guardian #2): _____ Work Phone: _____

Address of employment (guardian #2): _____

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: _____

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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 Center – 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? Yes No

If yes, care plan must be provided on or before the first day of care.

Is your child fully immunized? Yes No

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: _____

Nature & dates of any surgeries or severe injuries: _____

Is your child on any medications? Yes No

If yes, please explain: _____

Does your child have any physical limitations? Yes No

If yes, please explain: _____

Does your child have any dietary restrictions? Yes No

If yes, please explain: _____

Please list any activities that you prefer your child NOT participate in:

Allergies & Nature of Reaction

Insect Stings: _____

Medication/Drugs: _____

Food: _____

Other: _____

Please list any other chronic conditions:

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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:** _____

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Contact Information (Classroom Copy)

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

Allergies: _____

Parent or Guardian #1

Name: _____

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

Parent or Guardian #2

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: _____