Registration and Emergency Contact Form

Child's Name _____ **Date of Birth** _____

Street Address _____

City, State & Zip _____ Sex: Male or Female (please circle)

Known Allergies (food/medicine) _____

Mother's Name _____

Street Address _____

City, State & Zip _____

Home Phone _____

Cell Phone _____

Email _____

Employer _____

Work Address _____

Work Phone _____

Father's Name _____

Street Address _____

City, State & Zip _____

Home Phone _____

Cell Phone _____

Email _____

Employer _____

Work Address _____

Work Phone _____

Emergency Contacts that are ALSO ALLOWED TO PICK UP YOUR CHILD

Name _____

Relationship _____

Street Address _____

City, State & Zip _____

Home Phone _____

Cell Phone _____

Name _____

Relationship _____

Street Address _____

City, State & Zip _____

Home Phone _____

Cell Phone _____

Days/Hours of Care

Days _____

Hours (ex: 8am-4pm, 9am-5pm, 7am-6pm) _____

Doctor Information

Name _____ **Hospital** _____

Street Address _____

City, State & Zip _____

Phone _____

5/2024