Updated 1/2024

# Enrollment Form 2024

Child's Name: ________________________________________ Date of Enrollment: ____________________

Home Address: ____________________________________________________________________________

Home Phone: _____________________ Sex: M F Age: _______ Date of Birth: _________________

Family Members: __________________________________________________________________________

Mother or Guardian's Name: _________________________________________________________________

Address if different from child's: ______________________________________________________________

Zip: _______ Home Phone: _______________ Cell Phone: _______________ Email: __________________

Name of Employment (Mother/Guardian): ________________________________________________________

Address of Employment: __________________________________________ Work Phone: _______________

Father or Guardian's Name: _________________________________________________________________

Address if different from child's: ______________________________________________________________

Zip: _______ Home Phone: _______________ Cell Phone: _______________ Email: __________________

Name of Employment (Father/Guardian): ________________________________________________________

Address of Employment: __________________________________________ Work Phone: _______________

Special instructions for reaching parent or guardian: _________________________________________________

Updated 1/2024

**Emergency Contacts:**

1. Name: ______________________________Home Phone: _________________Address: ___________________________

   Work Phone: _________________________________ Relationship to child: ___________________________________

2. Name: ______________________________Home Phone: _________________Address: ___________________________

   Work Phone: _________________________________ Relationship to child: ___________________________________

## Child Pickup Information

Persons Authorized to pick up your child (Must show photo ID)

Name: ________________________________________________________________________________________________

Home Phone: ______________________________________ Work Phone: _______________________________________

Name: ________________________________________________________________________________________________

Home Phone: ______________________________________ Work Phone: _______________________________________

Name: ________________________________________________________________________________________________

Home Phone: ______________________________________ Work Phone: _______________________________________

Name, address, and phone number of child's doctor:

__________________________________________________________

______________________________________________________________________________________________________

Name, address, and phone number of child's dentist:

__________________________________________________________

______________________________________________________________________________________________________

Hospital of Preference (Please indicate your preference in Case of Emergency:

__________________________________

__________________________________

__________________________________

Updated 1/2024

Chronic Medical Conditions: ______________________________________________

Does your child have a health care plan? __________

If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? ________

Complete immunization records must be provided on or before the first day the child is in care.

Food Allergies: ______________________________________________

## Health History

(Chronic or Recurring)

Ear Infections: ______________

Diabetes: ______________

Heart disease/defect: ______________

Convulsions/seizures: ______________

Asthma: ______________

Nosebleeds: ______________

Measles: ______________

Mumps: ______________

Chicken Pox: ______________

Flu or Flu Shot: ______________

## Allergies

(Nature of Reaction)

Hay Fever: ______________

Plant Poisoning: ______________

Insect Stings: ______________

Penicillin: ______________

Other drugs: ______________

Animals: ______________

Food: ______________

Other: ______________

Operations or serious injuries (dates): ______________________________________________

Is the child on any medications? (Explain): ______________________________________________

If yes, please describe: ______________________________________________

Physical Limitations: ______________________ Describe if yes: ______________________

Dietary Limitations: ______________________ Describe if yes: ______________________

Vision: ______________________ Hearing: ______________________

Are there any activities that you prefer that your child **NOT** participate in?

If so, please list: ______________________________________________

Updated 1/2024

I hereby give permission for Once Upon a Childcare to call a doctor or emergency medical services 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 is taken. If it is not possible to locate the emergency contacts that are listed, treatment will not be delayed. I/we will accept the expense of any emergency transportation, medical or surgical treatment.

Parent/Guardian Signatures:

______________________________________________ Date: ______________________

______________________________________________ Date: ______________________

Annual Updates

Parent/Guardian Signatures:

______________________________________________ Date: ______________________

______________________________________________ Date: ______________________

______________________________________________ Date: ______________________

______________________________________________ Date: ______________________