Child's Name: ________________________________ Enrollment Date: ___________________________

CHILD INFORMATION

Birthday: ________________ Current Address: ____

Names of other Household Members: ____

PARENT INFORMATION

MOTHER

Name:____

Home Address:____ E-Mail Address:______________________________________

Home Phone Number: ________________________________Cell Phone Number: ____________________________________

Work Name: ____

Work Address: ____

Work Phone Number: ________________________________Work E-mail Address: ____________________________________

FATHER

Name:____

Home Address:____ E-Mail Address:______________________________________

Home Phone Number: ________________________________Cell Phone Number: ____________________________________

Work Name: ____

Work Address: ____

Work Phone Number: ________________________________Work E-mail Address: ____________________________________

OTHER ADULTS APPROVED TO PICK UP THE CHILD

Name: ____________________________________ Name: __________________________________

Name: ____________________________________ Name: __________________________________

ADULTS APPROVED TO BE CONTACTED TO PICK UP CHILD IN THE CASE OF EMERGENCY

(If parents cannot be reached immediately)

Name(s):____

Home Address:____

Home Phone Number: ______________________________Cell Phone Number: __________________________________

Work Name: ____

Work Address: ____

Work Phone Number: ______________________________

Name(s):____

Home Address:____

Home Phone Number: ______________________________Cell Phone Number: __________________________________

Work Name: ____

Work Address: ____

Work Phone Number: ______________________________

MEDICAL INFORMATION

CHRONIC HEALTH CONCERNS:

Allergies, seizsures and/or other chronic health concerns:_______________________________________

____

Regular medications:____

PHYSICIAN

Name: ____

Address: ____

Phone Number: ____

DENTIST

Name: ____

Address: ____

Phone Number: ____

PREFERRED HOSPITAL (*Please check one*)

- ☐ POUDRE VALLEY HOSPITAL, 1024 S. Lemay Ave, Fort Collins, CO 80524 (970) 495-7000
- ☐ MEDICAL CENTER OF THE ROCKIES, 2500 Rocky Mountain Ave, Loveland, CO 80538 (970) 624-2500
- ☐ MCKEE MEDICAL CENTER, 2000 Boise Ave, Loveland, CO 80538 (970)820-4640
- ☐ BANNER FORT COLLINS MEDICAL CENTER, 4700 Lady Moon Dr., Ft. Collins, CO 80526 (970) 821-4000
- ☐ OTHER HOSPITAL (Please Specify) ____

INSURANCE (*if applicable*)

Provider Name:____

Plan Number:____

Policy Number: ____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby give my permission to _______________________ 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 signature

____Date ______________________