Updated 1/2022

Enrollment Form 2022

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: ____

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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 check one): ☐ UC Health Memorial Hospital
4050 Briargate Pkwy
Colorado Springs, CO 80920
719-364-5000

☐ St. Francis Medical Center
6001 E Woodmen Rd.
Colorado Springs, CO 80923

☐ Other ______________________________________
____
____

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: ______________________________________

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I hereby give permission to _______________ 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 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 any emergency transportation, medical or surgical treatment.

Parent/Guardian Signatures:

____ Date: ____________________

____ Date: ____________________

Annual Updates

Parent/Guardian Signatures:

____ Date: ____________________

____ Date: ____________________

____ Date: ____________________

____ Date: ____________________