

OPEN HEARTS CHILD CARE

BEFORE AND AFTER SCHOOL CHILD CARE

PRESCHOOL

BRIDGING THE GAP BETWEEN HOME AND SCHOOL

Child's Name	Birthdate
Address(Street, City, State, Zip Code)	

IDENTIFYING INFORMATION

A) Mother's Name	Home Telephone Number
Address (Street, City, State, Zip Code)	
Employed by	Hours of Employment
Address (Street, City, State, Zip Code)	Business Telephone Number
B) Father's Name	Home Telephone Number
Address (Street, City, State, Zip Code)	
Employed by	Hours of Employment
Address (Street, City, State, Zip Code)	Business Telephone Number

EMERGENCY CONTACT(S) OTHER THAN PARENTS OR DOCTOR

Name	Telephone Number
Address (Street, City, State, Zip Code)	
Name	Telephone Number
Address (Street, City, State, Zip Code)	

PERSON(S) AUTHORIZED TO TAKE CHILD FROM THE CHILD CARE FACILITY

Name	Telephone Number
Name	Telephone Number
Name	Telephone Number

TO BE COMPLETED BY CHILD CARE FACILITY

Admission Date	Discharge Date

PRESCHOOL [] M W F 8:30 – 11:30 am M W F 8:00 am – 3:00 pm	BEFORE & AFTER [] AM – M T W T H F PM – M T W T H F AGE [] GRADE LEVEL []	REGISTRATION FEE \$25.00 SUPPLY FEE \$25.00 PRESCHOOL \$ BEFORE & AFTER \$
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AUTHORIZATION FOR EMERGENCY MEDICAL CARE

PHYSICIAN AND PREFERRED HOSPITAL TO BE USED IN AN EMERGENCY

I understand that in case of an accident or injury to my child, I will be notified immediately. If my child requires emergency medical care, Open Hearts Child Care has the authority to take my child to the following hospital: (The physician and preferred hospital to be used.)

Name of Doctor/Clinic

Telephone Number

Preferred Hospital

Telephone Number

FIELD TRIPS AND TRANSPORTATION: Complete this section only if facility takes field trips or provides transportation. I DO I DO NOT give my consent for my child to take part in field trips or excursions with this day care facility, under proper supervision. It is my understanding that I will be notified when such trips are planned.

AGREEMENTS

- A. I have been informed of the required health & safety inspections and that the inspection forms are available for review.
- B. When my child is ill, I understand and agree that my child may not be accepted for care.

Parent/Legal Guardian Signature

Date

HEALTH REPORT FOR SCHOOL-AGED CHILD

CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS

Any allergies, special medical conditions (including chronic health problems):

Any special medications and/or restrictions:

This certifies that my child is to my knowledge, in good health and free of disabilities that would endanger him/her or other children in day care.

Parent/Legal Guardian Signature

Date

IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

DATES GIVEN

IMMUNIZATIONS	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	DOSE 6
DTaP/DT						
Polio						
PCV						
Hib						
MMR						
Hepatitis B						
Varivax						