DROP-IN REGISTRATION FORM
CHILD INFORMATION

Child's Picture

Child's Full Name:

_____

SEX:
Male [ ]
Female [ ]

CHILD'S HOME ADDRESS:

_____

DATE OF BIRTH:

_____

HOME TELEPHONE NUMBER:

_____

DATE OF ACCEPTANCE:

_____

MEDICAL INFORMATION

Does your child have any allergies? Yes [ ] No [ ]
If Yes, what is your child allergic to?
_____

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:

_____

Telephone Number:

_____

Child's Source of Dental Care/Dentist's Name:

_____

Telephone Number:

_____

Name Of Medical Care Facility/Hospital:

_____

Telephone Number:

_____

EMERGENCY CONTACTS

Name	Relationship to Child	Telephone Number During Childcare	Other Telephone Number

APPLICANT INFORMATION

NAME OF PERSON APPLYING FOR CHILD: _____

Parent [ ] Guardian [ ] Caretaker [ ] Relative [ ] Other [ ]

DAYTIME TELEPHONE NUMBER:

_____

ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):

_____

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the governing regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park, playground) away from the facility under proper supervision. Yes [ ] No [ ]

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. Yes [ ] No [ ]

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. Yes [ ] No [ ]

I agree to review and update this information whenever a change occurs and at least once every six months. Yes [ ] No [ ]

Provider/Facility Name and Address:

__The West Village Community Drop-In. 150 West Village Place, #328_____

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:

_____

DATE:

_____