Seed of Life
Center for Early Learning and Preschool, Inc.

# CHILD CARE REGISTRATION FORM

| | |
|---|---|
| Date child entered care | |
| Date child left care | |

**Child's name**

| First | Middle | Last |
|---|---|---|
| | | |

| Name used | Birth Date |
|---|---|
| | |

| Street address | City | Zip code | Email: |
|---|---|---|---|
| | | | |

**#1 Child's parent/guardian name**

| telephone/cell number & carrier | 10 digit work telephone number |
|---|---|
| | |

| Street address | City | Zip code |
|---|---|---|
| | | |

| Address where you can be reached while child is in care | City | Zip code |
|---|---|---|
| | | |

**#2 Child's parent/guardian name**

| telephone/cell number & carrier | 10 digit work telephone number |
|---|---|
| | |

| Street address | City | Zip code |
|---|---|---|
| | | |

| Address where you can be reached while child is in care | City | Zip code |
|---|---|---|
| | | |

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| Other people to notify if parent 1 or 2 cannot be contacted during an emergency | | |
|---|---|---|
| **Legal Name** | **Address** | **10 digit telephone number** |
| **Relationship:** | | **Work:**<br>**Home:** |
| **Relationship:** | | **Work:**<br>**Home:** |
| **Relationship:** | | **Work:**<br>**Home:** |
| **Relationship:** | | **Work:**<br>**Home:** |

| Other than you (parent 1 or 2), who else has permission to pick up your child? | | |
|---|---|---|
| **Legal Name** | **Address** | **10 digit telephone number** |
| | | **Work:**<br>**Home:** |
| | | **Work:**<br>**Home:** |
| | | **Work:**<br>**Home:** |
| | | **Work:**<br>**Home:** |

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| Who does not have permission to pick up your child? Documentation of a restrain order has to be provided. | |
|---|---|
| **Name** | **Reason** |
| | |

| Child's health information | | |
|---|---|---|
| **Date of child's last physical exam:** | **Child's health care provider** | **10 digit telephone number** |
| | | |

| Street address | City | Zip code |
|---|---|---|
| | | |

| Special health problems | Allergies, including drug reactions |
|---|---|
| | |

| Regular medications | Other important information |
|---|---|
| | |

| Child's dentist's name | 10 digit telephone number |
|---|---|
| | |

| Street address | City | Zip code |
|---|---|---|
| | | |

| Child's medical insurance coverage | |
|---|---|
| **Insurance company name:** | **Member/policy number:** |
| **Policy holder name:** | **Employer name:** |
| **Insurance company name:** | **Member/policy number:** |
| **Policy holder name:** | **Employer name:** |

## Consent to medical care and treatment of minor children

I give permission that my child, _____

may be given emergency treatment by a qualified child care provider at

**Seed of Life Center for Early Learning and Preschool, Inc @ MLK 6725 45th Ave S, WA 98118,**

**Name and/or address**

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

| #1 Parent/guardian signature | Date | #2 Parent/guardian signature | Date |
|---|---|---|---|
| | | | |