



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



Other people to notify if parent 1 or 2 cannot be contacted during an emergency

Legal Name	Address	10 digit telephone number
Relationship:		Work: Home:
Relationship:		Work: Home:
Relationship:		Work: Home:
Relationship:		Work: 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: Home:
		Work: Home:
		Work: Home:
		Work: Home:



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 @ RB 8825 Rainier Ave S.Seattle, 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