

REGISTRATION FORM



Please complete all fields on this registration form as all information is required by MN DHS.

CHILD'S INFORMATION

Last Name: _____ First Name: _____
Nickname: _____ Birth Date: _____
Address: _____ City, State, Zip: _____
Start Date: _____ Classroom: _____

Name of siblings and birthdates: _____
Most recent child care provider: _____ In Home Center
Who does the child live with? _____

FAMILY INFORMATION

MOTHER / GUARDIAN #1:

Last Name: _____ First Name: _____
Relationship to Child: _____ Cell Phone: _____
Address: _____ Can you receive texts? Yes No
City, State, Zip: _____ Employer: _____
Email: _____ Work Phone: _____
Which is the best method of communication during the day? Work Cell Email Text

FATHER / GUARDIAN #2:

Last Name: _____ First Name: _____
Relationship to Child: _____ Cell Phone: _____
Address: _____ Can you receive texts? Yes No
City, State, Zip: _____ Employer: _____
Email: _____ Work Phone: _____
Which is the best method of communication during the day? Work Cell Email Text

ATTENDANCE

My child/ren is / are enrolled in New Creations Child Care and Learning Center and will attend New Creations from approximately _____ a.m. to _____ p.m. on the following days:

Monday Tuesday Wednesday Thursday Friday

EMERGENCY INFORMATION

EMERGENCY / AUTHORIZED PICK UP CONTACTS

Your child will ONLY be released to an authorized person listed on this form. In case of an emergency or an unforeseen circumstance, please indicate the name, relationship, phone number and full address of any other persons who you authorize to pick up your child on your behalf. **Names listed below must be someone OTHER THAN Parent / Guardian.** Please list in order of preferred contact. All blanks must be filled in.

1. Name: _____ Relationship to Child: _____
Phone: _____ Full Address: _____
2. Name: _____ Relationship to Child: _____
Phone: _____ Full Address: _____
3. Name: _____ Relationship to Child: _____
Phone: _____ Full Address: _____

****A parent / guardian's verbal authorization for pick up must be received before your child will be released to anyone not listed above. If not received, and we cannot get in touch with you by phone, your child will NOT be released****

MEDICAL / DENTAL INFORMATION

Pediatrician: _____ Office Phone: _____
Address: _____ City, State, Zip: _____
Medical Insurance Co: _____ Child's Personal ID# _____
Allergies or Medical conditions / needs: _____

Dentist: _____ Office Phone: _____
Address: _____ City, State, Zip: _____

****Please use your dentist even if your child is not yet being seen. All blanks must be filled in****

EMERGENCY CONSENT

It is our policy to notify a parent when a child is ill or needs medical attention. Occasionally, we cannot contact a parent and we need to get immediate help for the child. Our procedure is to take the child to the nearest emergency service.

Please sign below so that we may take appropriate action on behalf of your child.

**I / WE HEREBY GIVE MY / OUR CONSENT FOR MY CHILD _____
WHEN ILL / INJURED TO BE TAKEN TO THE NEAREST EMERGENCY CENTER BY THE STAFF
OF NEW CREATIONS CHILD CARE AND LEARNING CENTER WHEN I / WE CANNOT BE
CONTACTED. I CONSENT TO AN AMBULANCE BEING CALLED TO TRANSPORT THE CHILD, IF
NECESSARY. I FURTHER AGREE TO PAY ALL COSTS INCURRED FOR TRANSPORT.**

Parent / Guardian Signature

Date

Director Signature

Date

HEALTH AND MEDICAL HISTORY

Has your child ever had any of the following? Check all that apply.

- Chicken Pox Scarlett Fever Diabetes Measles
- HIV Aids Hepatitis A Hepatitis B
- Mumps Asthma Other - Explain: _____

Does your child frequently have any of the following? Check all that apply.

- Ear Aches Colds Sore Throat Stomach Aches

Does he / she vomit easily? Yes No

Run high fevers easily? Yes No

Has your child had any serious accidents? Yes No

If yes, please explain: _____

Does your child have any allergies? Yes No If yes, please explain what allergies your child has and when / how it manifests (asthma, hay fever, hives, etc.):

Has your child ever been hospitalized? Yes No

If yes, please explain: _____

Has your child ever been to a dentist? Yes No

Does your child have any disabilities or exceptionalities we need to be aware of? Yes No

If yes, please explain: _____

How do you find your child's overall health to be?

Parent / Guardian Signature	Relationship to Child	Date
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TO BE FILLED OUT BY NEW CREATIONS

Parent / Teacher Conference Date #1 _____

Summary: _____

Parent / Teacher Conference Date #2 _____

Summary: _____
