St. Mary's Extended Day Registration Form

Division of Public Health - Licensure Unit - Children's Services Licensing Program

Children's Record

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name:____________________ Birthdate(s): ____________________

Enrollment Date:__________ Updates:__________ Date Care Ceased: __________

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: ____________________ Employer:____________________

Address:____________________ Address:____________________

City: __________ Phone: __________ City: __________ Phone:__________

MOTHER (or Guardian):

Name: ____________________ Employer:____________________

Address:____________________ Address:____________________

City: __________ Phone: __________ City: __________ Phone:__________

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name: ____________________ Name: ____________________

Address:____________________ Address:____________________

City: __________ Phone: __________ City: __________ Phone:__________

Name: ____________________ Name: ____________________

Address:____________________ Address:____________________

City: __________ Phone: __________ City: __________ Phone:__________

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: ____________________ Name: ____________________

Address:____________________ Address:____________________

City: __________ Phone: __________ City: __________ Phone:__________

Name: ____________________ Name: ____________________

Address:____________________ Address:____________________

City: __________ Phone: __________ City: __________ Phone:__________

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to ______________________
Caregiver

to contact Doctor ______________________ ______________________
Name of Physician Phone

______________________ and, if necessary, take my child(ren) to the
Address City

following doctor(s), clinics, or hospital ______________________

______________________ ______________
Signature of Parent/Guardian Date

MEDICATION COMPETENCY STATEMENT

I, ______________________ have determined
Parent /Guardian Name

that ______________________ is/are competent to give or apply medication to my child(ren).
Provider/Director/Staff Name(s)

______________________ ______________
Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

Current health status or any health problems caregiver should know: ______________________

Medication, if any: ______________________

List any allergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: ______________________

Special Concerns: (Glasses, Hearing Aid, Crutches) ______________________

Any activities child(ren) should NOT engage in: ______________________

Company providing health and/or accident insurance coverage: (Optional) ______________________

I certify that the above information is correct to the best of my knowledge.

______________________ ______________
Signature of Parent/Guardian Date