

2011-2012 LAKEWOOD MDO REGISTRATION

CHILD'S NAME _____

CHILD'S NICKNAME _____ SEX _____ DATE OF BIRTH _____

Home Address _____ Email: _____

City _____ State _____ Zip _____ Home Phone _____

MOTHER'S INFO

Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____ Work Hours _____

Email Address _____

Home Address (if different than child's)

Driver's License# _____

FATHER'S INFO

Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____ Work Hours _____

Email Address _____

Home Address (if different than child's)

Driver's License # _____

EMERGENCY CONTACT INFO

If parents cannot be reached in an emergency, please contact:

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Address _____

Is this person authorized to take the child from the center? _____

Other Adults who are authorized to take the child from the center:

1. Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Address _____

2. Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Address _____

3. Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Address _____

MEDICAL INFO

Child's Physician _____ Doctor's Phone _____

Doctor's Address _____

Hospital Preference _____

MORE MEDICAL INFO

Diseases and Conditions: Circle **Y** for Yes or **N** for No and list dates where applicable.

Measles: Y N Date _____
Mumps: Y N Date _____
German Measles: Y N Date _____
Chicken Pox: Y N Date _____
Whooping Cough: Y N Date _____
Tuberculosis: Y N Date _____
Frequent Colds: Y N _____
Frequent Ear Infections: Y N _____
Frequent Throat Infections: Y N _____

Defective Heart: Y N _____
Diabetes: Y N _____
Seizures/Fainting Spells: Y N _____
Sun Sensitivity: Y N _____
Daily Medication(s): Y N Please list _____

Other Medical Conditions or Comments: _____

Allergies:

Non-food Allergies: Y N Symptoms _____

Food Allergies: Y N Which foods? _____

Immunizations: Please provide a copy of your child's Immunization Record.

Verified by (check one): Health Department Record ___ Physician's Record ___ Other ___

MEDICAL RELEASES

I, _____, Father _____ Mother _____ (CROSS OUT WORDS THAT DO NOT APPLY)
(Please print your name) Guardian _____

of _____ do hereby give my consent to the Director of the Child Care
(Child's Name)

Facility, or her due representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or her duly appointed representative to transport said child for emergency medical treatments, if the parents cannot be reached.

Signature _____ Date _____

I hereby give / do not give (CIRCLE ONE) the Director of the Child Care Facility or her duly appointed representative permission to give _____ acetaminophen. I
(Child's Name)
understand I will be notified that the medication has been administered.

Signature _____ Date _____

CHILD'S DEVELOPMENTAL INFO

Physical or emotional problems child might have _____

Other special food needs _____

Is child toilet trained? Y N Words used in toileting _____

Siblings? Y N Name(s) _____ Type of childcare used previously _____

Favorite: Toys _____ Games _____

Other useful info _____